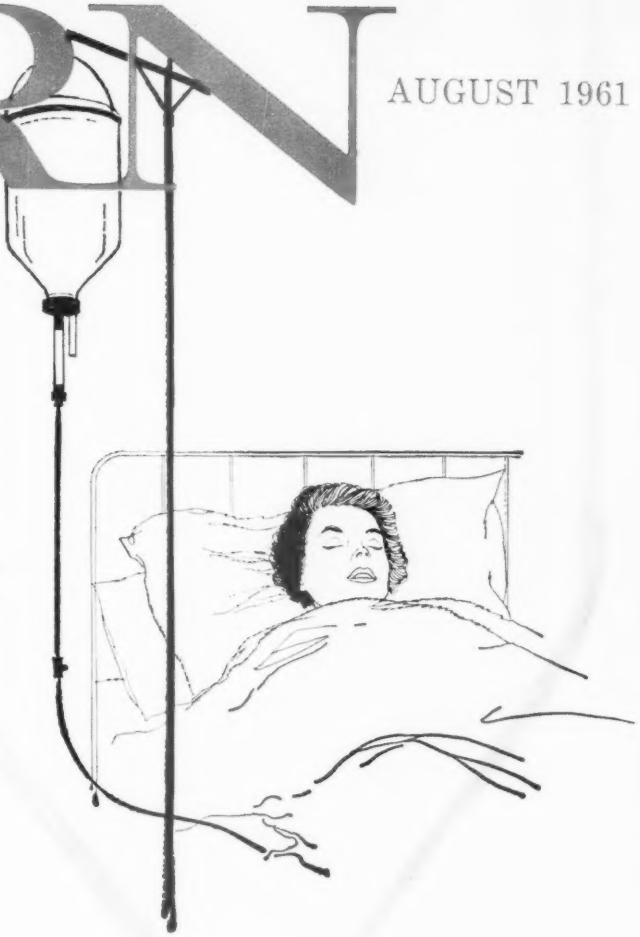
RN

AUGUST 1961



Some pointers on I.V. therapy

RN contents

VOLUME 24 • NO. 8 • AUGUST 1961

MORE▶

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. . . contents

DEPARTMENTS and SHORT FEATURES

RN

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2. Ovulation suppression (to suspend fertility). For this purpose ENOVID is administered *cyclically,* beginning on day 5 through day 24 (20 daily doses). The ovary remains in a state of physiologic rest and there is no impairment of subsequent fertility.

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4. Threatened abortion. *Continuous* ENOVID treatment provides balanced support for the endometrium in threatened or habitual abortion.

5. Endocrine infertility. ENOVID has been used successfully in *cyclic* therapy of endocrine infertility, promoting subsequent pregnancy through a probable "rebound" phenomenon.

6. Endometriosis. *Continuous* therapy with ENOVID corrects endometriosis by producing a pseudodecidual reaction with subsequent absorption of aberrant endometrial tissue.

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aureus

patients suggested

infection in hospitals!

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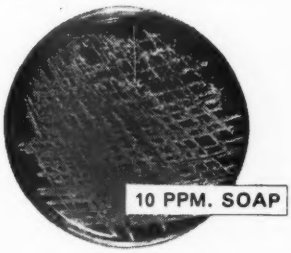

1. Ordinary toilet soap left this heavy Staph growth.

2. A widely used antiseptic soap showed little inhibition of Staph.

3. Dial Soap completely inhibited the growth of Staphylococcus aureus.

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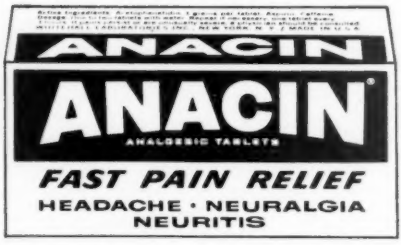

Reference: 1. Hardy, James D.: The Nature of Pain, J. of Chronic Diseases, Vol. 4, July, 1956.

WHITEHALL LABORATORIES, NEW YORK, N.Y.

RN letters

STAFF ACCREDITATION?

DEAR EDITOR: Your recent article "You Have a Stake in Hospital Accreditation" leads me to ask: Does the accrediting agency give *any* consideration to the education, experience, and professional affiliations of staff nurses? If it does, the list of questions with the article doesn't show this.

In being hired by hospitals, I've never been asked to show my state registration, or if I'm eligible for membership in a professional organization. Shouldn't an accredited hospital ask to see an R.N.'s credentials when hiring her?

Our status would certainly be strengthened if the accrediting agency *did* consider our professional qualifications as a part of its requirements.

Elsie C. Kohlmann, R.N.
St. Louis, Mo.

Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, says his agency assumes that each R.N.'s professional qualifications are checked by her employer before she is hired. "Any director of nurses who fails to do this is guilty of negligence," he adds. "The law specifically requires hospitals to exercise 'due and ordinary care' in this regard."—ED.

LISTENING'S FUN

DEAR EDITOR: When I'm in a crowd I never tell others I'm a nurse. It's fun just to listen to unguarded comments about hospitals, doctors, and nurses.

I know other R.N.s who also keep mum in such circumstances. This way we sometimes learn how to improve our relationships with patients.

Annetta Wilson, R.N.
Ypsilanti, Mich.

AGAINST 'BRASS-POLISHING'

DEAR EDITOR: An *RN*-reader recently urged the adoption of a merit system for hospital nurses which, she said, "would benefit nursing in many ways." I disagree.

A merit system would require efficiency ratings, thus increasing the paper work of the supervisory staff. Worse still, it would require a means of evaluating the evaluators. Otherwise, it could lead to favoritism. (I've seen two excel-

...*letters*

lent nurses denied promotion because of unfair efficiency ratings.)

Let's not fall into the same trap that has ensnared the armed forces, where "brass-polishing" is a *must!*

Margaret J. Black, R.N.
Hermosa Beach, Calif.

ORDERED AROUND

DEAR EDITOR: I'd like to see the medical profession recognize the nurse as a member of the medical team. R.N.s would appreciate such recognition. Many doctors order us around as though we were domestic servants!

Edith M. Ortner, R.N.
Appleton City, Mo.

TEEN-AGE AIDES

DEAR EDITOR: As a nursing administrator, I've heard hundreds of starry-eyed high school girls say they want jobs as junior aides "to see what nursing is like." And I'm well aware that many R.N.s favor this approach to a nursing career. I don't.

Thrusting an adolescent into hospital life without proper orientation is like forcing a baby to walk before he can crawl.

Perhaps some hospitals *do* give their junior aides *proper* orientation. But in most, the "orientation" goes like this:

We take the youngster to the locker room where she overhears —what? Somebody loudly griping about something! So we hurry

her off to the medical floor. There, after the briefest of briefings, she's put to work stacking linen or cleaning the utility room. Within a few hours—and without further instruction—this untrained adolescent is in direct contact with sick patients.

Even under the best of circumstances, how could we possibly prepare a 15-year-old to cope with problems that trouble the long-experienced? Suppose, for example, a patient asks her: "Did my doctor say I've got cancer?" We can't expect her to show adult intelligence in such a situation.

In some hospitals, junior aides attend an "orientation class." What do they learn there? Usually, how to pass trays and fill water carafes! We seem to think that girls who can only "help out" after school don't need much instruction.

As a result, many junior aides turn to older aides and L.P.N.s for answers to their questions. Often, they learn to do things the wrong way. Then if they enter nursing school, they have to unlearn—with difficulty—the few things they already know.

How, then, can we encourage the interested teen-ager without exposing her (as a paid employe) to the traumatic realities of the hospital world before she's ready to face them?

Some hospital schools have nurse-recruitment programs that

include get-acquainted visits to the dormitories and guided tours of the hospital. This idea seems to me a far better approach than the use of teen-agers as paid aides.

In any event, I'd certainly discourage a daughter of mine from "playing" at nursing during adolescence.

R.N., Illinois

The editors invite your comments on this controversial subject.

APPRECIATION

DEAR EDITOR: *RN* is the magazine for busy nurses. It's up-to-date, concise, and interesting. I especially appreciate the fact that it keeps me informed without requiring me to struggle through writing that resembles a classroom assignment.

Wilma Smucker, R.N.
Harrisonburg, Va.

NOTE FROM OVERSEAS

DEAR EDITOR: In an *RN* letter, a Georgia nurse "feels sorry for nurses who don't seem to get any joy from nursing—only from their pay checks." I have worked with American nurses for ten years and have never met one like that.

Alida Jansen
Leiderdorp, The Netherlands

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RN news

Oregon law gives nurses bargaining rights

Oregon recently became the first state in the nation to require nonprofit hospitals and nursing homes to bargain collectively with their nurse-employes. Under Federal law, such institutions have been exempt from this requirement.

The Oregon law, which includes a "no strike" clause, was passed by the legislature at the urging of the state nurses' association. It covers practical as well as professional nurses. It brands failure to bargain collectively as an unfair employment practice and provides for mediation through a state agency.

Similar measures are reportedly pending in several states.

R.N. student total rises; degree programs gain

Admissions to all types of professional nursing schools rose about 4 per cent in 1960 over 1959 (49,787 as compared with 47,797), according to figures compiled by the National League for Nursing. Admissions to practical nursing schools rose only 1 per cent.

Diploma schools continued to account for the largest enrollment in the professional programs: 39,219, or 78.7 per cent. But for the first time, increased enrollment in baccalaureate and associate degree programs pushed diploma school enrollments below the 80 per cent mark. The figures: baccalaureate degree enrollments, 17 per cent; associate degree enrollments, 4.3 per cent.

Nurse-shortage committee geared for action

The nurse is "the magic ingredient" in health services, Health, Education, and Welfare Secretary Abraham Ribicoff told the U.S. Public Health Service Surgeon General's Consultant Group on Nursing at its first meeting in Washington in June (see *RN*, July, p. 19). "If we are expanding in every field of health and medicine, we will be self-defeating if we do not do something about the shortage in nursing."

Boisfeuillet Jones, the Secretary's special assistant for health and medical affairs, said that President Kennedy hopes the committee will (1) outline problems in nursing and the best ways

Notable Success with VISTARIL...

in prepartum tension and anxiety		allays anxiety without impairing ability to cooperate during labor and delivery[1]	reduces narcotic requirements and incidence of narcotic-induced respiratory depression, helps control emesis[1,4]
in the cardiac or the hypertensive patient		allays anxiety without adverse influence on blood pressure[2]	helps correct certain functional arrhythmias, does not increase gastric secretion[2]
in problem drinkers		allays anxiety—makes patient more manageable[3]	produces no significant depression of blood pressure, pulse rate, or respiration. No liver involvement reported
in preoperative tension and anxiety		allays anxiety without depression of vital functions[4]	reduces incidence of narcotic-induced respiratory depression and hypotension, relaxes skeletal muscle, smooths recovery and helps control emesis[4]
in pediatrics		allays tension in agitated, hyperkinetic patients	avoids danger of liver damage or other untoward reactions

References: 1. Benson, C., and Benson, R. C.: Scientific Exhibit, Illinois Acad. Gen. Practice, Sept., 1960. 2. Salmons, J. A.: Dis. Chest 38:105, 1960. 3. Major, R. A.: GP 21:104, 1960. 4. Grady, R. W., and Rich, A. L.: Scientific Exhibit, Am. Soc. Anesth., New York, Oct. 4-7, 1960.

. . . *news*

to handle them, and (2) make legislative proposals to solve them. Surgeon General Luther L. Terry added that "of all Federal committees over recent years, none has had such a complicated job."

In an interview with *RN* the day following the two-day meeting, Committee Chairman Alvin C. Eurich emphasized that the group will deliver a constructive report. "I have no interest," he said, "in filing a report and having it put on a shelf to be picked up twenty years later. Nurses themselves can help us implement the findings and recommendations of our committee when we report them at the end of this year. There are over a half million nurses in this country. If they all talked to their patients about the importance of nursing, we'd have a lot of public support. Doctors have been talking to their patients about public issues for years. It's time nurses started doing so, too."

Canadian nurses get new home-study course

Ever wished that advanced courses in nursing were available on a home-study basis, as they are in some other fields?

This fall, a start toward that goal will be made in Canada. There, supervisory nurses can enroll in a course to help them improve their floor-management skills.

The course opens with a five-

diaper rash & minor skin irritations

are relieved by Caldesene® ointment or powder

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...news

day workshop, offered in six locations to keep travel to a minimum. The nurse next receives thirteen lessons, mailed to her at two-week intervals. To complete the course, she then attends a second workshop which is scheduled for May.

The tuition is $100; textbooks, $20-$25. The course is sponsored by the Canadian Nurses' Association and the Canadian Hospital Association. It's aided financially by the W. K. Kellogg Foundation of Battle Creek, Mich.

'These health problems could be solved IF—'

Medical science has the knowledge and techniques needed to solve such problems as TB, cervical cancer, venereal disease, and the prevention of blindness; to control dental decay, rheumatic fever, and X-ray exposure; to reduce traffic injuries and disability; and to expand home-nursing care. But public health authorities are stymied by a lack of funds and trained personnel.

So, in effect, says the Public Health Service in a report to a Congressional committee on appropriations.

The report stresses, among other things, the need for (1) widespread use of the Pap smear test; (2) fluoridation of the nation's drinking water; (3) inspection of medical/dental X-ray units; (4) promotion of seat-belt use in au-

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RN12

tos; and (5) establishment of home-nursing service in communities that don't have it.

New treatment said to benefit hemiplegics

Electrical stimulation of the hemiplegic's muscles by a sinusoidal current during exercise is helpful in treating paralysis of an upper extremity.

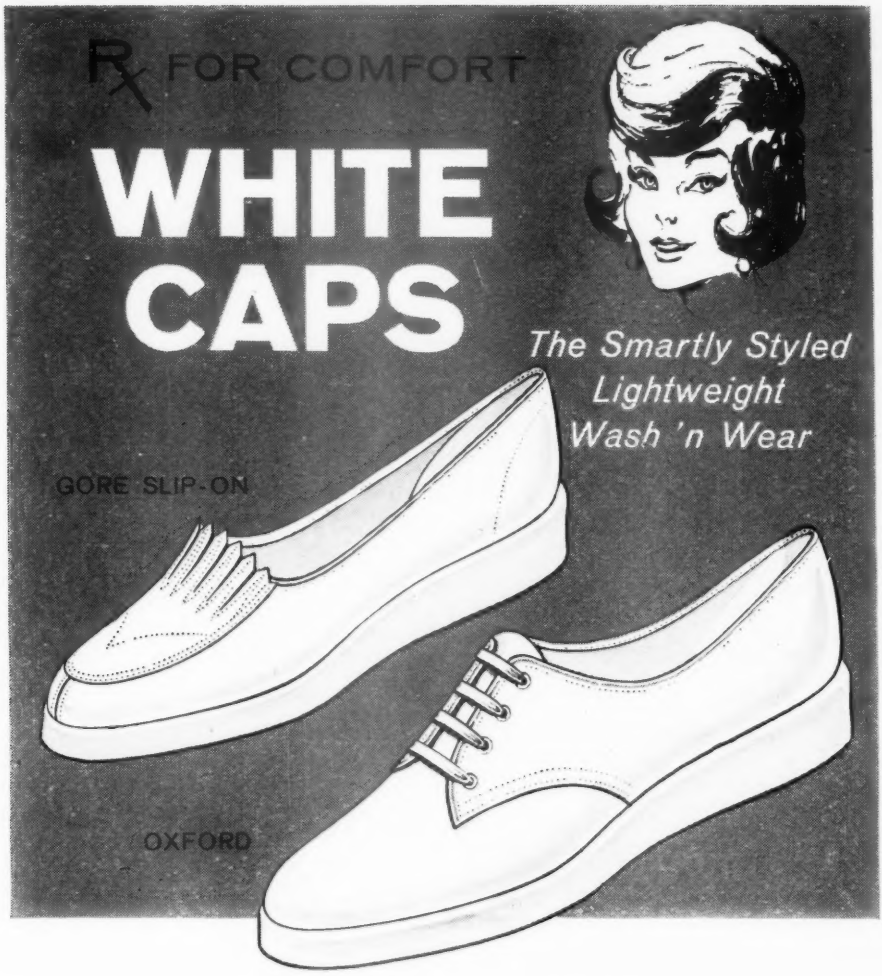
So says Dr. Harry T. Zankel of the Veterans Administration Hospital in Durham, N.C., reporting in Geriatrics magazine.

The treatment, called stimulation assistive exercise (SAE), is given for a half-hour, twice to four times daily. After each treatment the patient is encouraged to do overhead pulley exercises for another half-hour.

Three-fourths of twenty-seven hemiplegics so treated showed satisfactory to excellent improvement, the doctor says.

capsules

Because the medical profession controls the distribution of **narcotics** in Britain, there's no organized drug peddling there; hence, there's no such addiction problem as exists in the U.S., contends a joint committee of the A.M.A. and the



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American Bar Association. The committee urges a thorough review of U.S. policy. It suggests that the problem be regarded as a medical rather than a criminal one. . . .

Surgical nightmare: A Cleveland M.D., stricken suddenly with hernia symptoms while assisting at an open-heart operation, stayed on the job till it was done, then had his hernia repaired in an adjoining O.R. by the surgeon he'd been assisting. . . .

Office nurses in at least three areas (Detroit; Madison, Wis.; and Long Island, N.Y.) are helping in a drive to gather doctors' **unused drug samples** for the use of medical missionaries abroad. Besides aiding needy missions, this method of disposing of samples should keep them from falling into the hands of drug bootleggers, say medical society spokesmen. . . .

Bruxism—the habit of unconsciously **gnashing one's teeth**—overtaxes the jaw muscles and causes chronic headache, says British investigators. For prevention, they suggest that an appliance called a "relaxation plate" be worn on the upper jaw. END

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*J.A.M.A. *169*:41-45 (Jan. 3) 1959. 56461

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RN

Drugs in gynecology

BY MORTON J. RODMAN, PH.D.

In Part I of this two-part article (RN, *July, 1961*) *the author explained how hormones control the menstrual cycle. He discussed the use of steroid and nonsteroid estrogens, progesterone, and androgens in the treatment of the menopause, secondary amenorrhea, and metrorrhagia. Here he considers these and other drugs as used in premenstrual tension, dysmenorrhea, endometriosis, contraception, and habitual abortion.*

Today a number of new synthetic steroids have largely replaced natural progesterone in gynecologic therapy. These easy-to-take progestins are being used in secondary amenorrhea and metrorrhagia. They're also used successfully in treating premenstrual tension and dysmenorrhea, which we'll discuss here.

True premenstrual tension is a potentially serious illness. It begins about ten days before the menstrual period and may build up gradually until it mimics the onset of mental illness. The afflicted woman may at first be restless and unable to concentrate. Later, she may have unreasonable emotional outbursts and suffer crying spells. Headache, backache, painful breast fullness, and other bodily discomfort may accompany the upset.

The exact causes are uncertain. But some researchers have

found that in severe cases estrogen levels are excessively high and progesterone levels low during the second half of the menstrual cycle. The excess estrogens, they believe, make fluids pile up in the tissues, including the brain. The slight cerebral edema may account for the patient's disturbed behavior.

To bring the estrogen-progesterone ratio back to normal the doctor gives progestins for two weeks before the expected period. This counteracts the fluid-retaining effect of the estrogens and may have a mild sedative action. He may also give an oral diuretic and a tranquilizer.

In dysmenorrhea (painful menstruation), certain new ovarian factors as well as pro-

Drugs for menstrual pain and abortion

Entries on this list start with the official or generic name of each drug, followed in parentheses by its trade name(s) and/or synonym(s).

Natural and synthetic corpus luteum hormones

Progestational steroids (progestins, or progestogens)
Ethisterone, U.S.P. (Lutocylol, Pranone)
Hydroxyprogesterone acetate (Prodox)
Hydroxyprogesterone caproate, N.N.D. (Delalutin)
Medroxyprogesterone acetate, N.N.D. (Provera)
Norethindrone, N.N.D. (Norlutin)
Norethynodrel (Enovid°)
Progesterone, U.S.P. (Corlutone, Corpomone, Lipo-Lutin, Lucorteum, Lutromone, Progesterone, Progestin, Prolutin)
Nonsteroid uterine-relaxing factors
Lututrin, N.N.D. (Lutrexin)
Relaxin, N.N.D. (Cervilaxin, Releasin)

° Contains a small amount of estrogen.

Some oral diuretics used in premenstrual tension

Acetazolamide, U.S.P. (Diamox)
Chlorothiazide, U.S.P. (Diuril)
Hydrochlorothiazide, U.S.P. (Esidrix, Hydro-Diuril, Oretic)
Trichlormethiazide (Metahydrin, Naqua)

Some new tranquilizing and antiemetic agents

Chlorpromazine HCl, U.S.P. (Thorazine)
Perphenazine, N.N.D. (Trilafon)
Prochlorperazine, N.N.D. (Compazine)
Thiopropazate dihydrochloride, N.N.D. (Dartal)
Trifluopromazine HCl, N.N.D. (Vesprin)

gestins may be given. One antispasmodic factor, lututrin (Lutrexin), is said to prevent uterine cramps in many women when taken by mouth before the onset of symptoms. Another factor, relaxin (Cervilaxin, Releasin), is being tested as a menstrual-pain treatment.

Unlike these factors, the progestins don't prevent painful uterine contractions. Instead, they act on the pituitary gland, reducing its production of gonadotropic hormones that stimulate ovulation. (It's believed there's some connection between menstrual pain and ovulation.) The result: When they're given for several days before and several days after the middle of the menstrual month, they prevent the ovum from being released.

What the synthetic progestins do, of course, is to produce a pseudopregnancy each time they're given this way! In true pregnancy, the presence of a fertilized ovum causes an increase in progesterone output. This, like the medically administered progestins, causes the pituitary gland to reduce its production of gonadotropic hormones, thus preventing ovulation for the duration of the pregnancy.

Producing a pseudopregnancy has several important medical uses other than the relief of dysmenorrhea. For instance, when used on women with endometriosis, it has helped some of them avoid radical surgery and subsequent sterility. (See "What You Need to Know About Endometriosis," page 59.)

Preventing ovulation means preventing fertilization and pregnancy. So several of the synthetic progestins have been tested as birth-control pills. One, norethynodrel (Enovid), was recently approved by the Food and Drug Administration for use as an oral contraceptive.

When taken daily from the fifth through the twenty-fifth day of each menstrual cycle, Enovid prevents ovulation and pregnancy. And it seems safe. Occasional nausea, headache, and dizziness are the only side effects reported. The nausea, like that of early pregnancy, can usually be controlled.

At first it was feared that

THE AUTHOR *is Professor of Pharmacology at the College of Pharmacy, Rutgers University, Newark, N.J., and a consultant to the U.S. Public Health Service.*

progestin-induced contraception might cause cancer or permanent sterility. This fear has proved unwarranted. No case of uterine or breast cancer has been traced to the progestins. In fact, the drugs are now being tried in cancer prevention.

Women who've used a progestin for child-spacing have been able to conceive readily after stopping the therapy. In some, pregnancy has occurred so rapidly that some doctors think resting the ovaries in this way may cause a "rebound effect"—that is, the ovum that's produced when the drug is stopped may be stronger and more likely to live. Thus, the drug may actually help women who have had difficulty conceiving.

The progestins have also proved successful in maintaining pregnancy in patients with corpus luteum failure. They're given to habitual aborters from the time of the first missed period until late in the pregnancy.

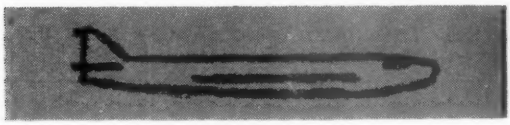
Such women usually don't produce enough progesterone to permit the endometrium to develop properly. The fertilized egg fails to implant itself firmly and doesn't develop as it should. High doses of progestins improve the uterine-lining environment so that the egg has a better chance.

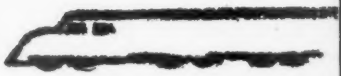
The new drugs have two advantages over the natural hormone in treating abortion. Some —for example, medroxyprogesterone acetate (Provera) and norethindrone (Norlutin)—are taken orally. Others are long-lasting in action. For instance, when hydroxyprogesterone caproate (Delalutin) is used, one injection lasts a week or longer. (Progesterone had to be injected daily.)

Of course, these new agents can't head off every abortion. In some cases the embryo dies before staining occurs. In others, the fertilized egg is so defective that no treatment will save it. Often, other measures besides the endocrines are used —for instance, bed rest, tranquilizers, and drugs that reduce uterine contraction.

Nevertheless, the synthetic progestins, purified estrogens, and other new gynecologic drugs are proving their worth. Judiciously administered under careful medical supervision, they're helping to maintain the health and well-being of millions of women. END

When your patient must travel by plane or train





BY EDITH S. OSHIN

"The doctor says I'm able to travel. What do I do now?"

The patient who asks you this may have a restrictive medical condition (for instance, heart trouble). He may be on crutches or in a wheel chair; or he may be a stretcher case. He has to travel a long distance and must use public transportation.

How do you answer him? Will the airlines or railroads accept him? Who decides for each company, and on what basis? What must he or his family do to get a reservation? Will the transportation company take special care of him during the trip?

By knowing the answers to these and similar questions, you can ease his mind and help him on his way. The questions that follow are the ones most apt to be worrying him. The answers bring you up-to-date on this subject.

How are special travel arrangements made?

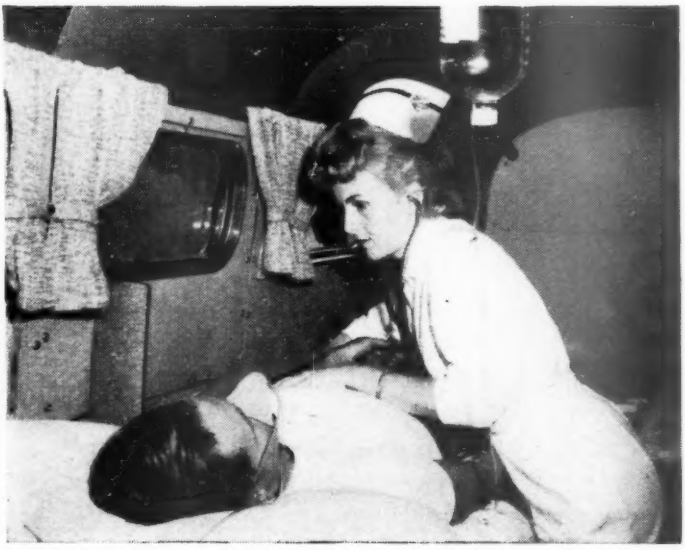
Get in touch with the transportation company's local agent. He may ask for a report from the attending physician (includ-

ing approval of the trip). If the case is complicated, he may submit the request to the company's medical department for its decision. In making a decision, the department considers (1) the safety and comfort of all passengers and (2) the space and equipment available on a specific carrier.

How far in advance should the patient apply?

In emergencies, public carriers do their best to give immediate service. At other times they require a few day's notice for wheel-chair patients and at least a week for stretcher patients so they can make special arrangements. For example:

¶ When a wheel-chair patient travels by air, his wheel chair is carried in the baggage compartment on the same plane. The airline notifies the airport at the patient's destina-



FLIGHT NURSE *Nancy L. Swanson of Canoga Park, Calif., takes her patient's blood pressure and keeps his I.V. flowing while the air ambulance speeds him to his home town.*

tion to be ready to remove the chair and take it to him.

¶ When a stretcher patient travels by train, it may be possible to load him aboard and unload him by driving an ambulance right up to the tracks. The railroad arranges a right-of-way with the stations concerned.

What patients are refused and why?

Those with communicable disease and, usually, those who are so ill they may die en route.

Airlines also refuse patients who would disturb or endanger others on the plane. These include the mentally incapacitated, the epileptic, and patients who have an offensive odor or appearance.

Because air pressure and oxygen vary at different altitudes, they also turn down infants under two weeks of age, patients

For the patient who needs a 'flying ambulance'

Suppose your patient who must travel is too sick to go by train or scheduled plane, or for some other reason wants to fly by commercial air ambulance. What can you tell him? This: There are air-ambulance companies that accept virtually every patient, and provide nursing care en route.

Schafer's Air Ambulance Service of Los Angeles is an example. Its specially fitted, twin-engine Beechcraft is on twenty-four-hour call. If requested, the company arranges for ambulance pick-up at the hospital and for delivery at the destination. Two relatives may accompany the patient.

What about the nursing care? Nancy L. Swanson, R.N. (see photo), or a substitute nurse provides it. Most of Mrs. Swanson's patients are seriously ill. She skillfully gives whatever care is needed en route, such as medications, I.V.s, and oxygen. In a year's time she flies nearly 100,000 miles and covers most of the United States. END

with active peptic ulcer, and those with some heart conditions or certain other complaints. They consider each borderline case individually and may, for instance, accept a heart patient who needs oxygen continuously. But the patient must provide his own oxygen supply and, if necessary, his own attendant.

When is an attendant required?

When, as in the above example, the patient can't care for his own needs. Polio victims, semiparaplegics, and others who use a wheel chair but aren't ill otherwise may travel unattended if they wish to.

Airlines usually limit wheelchair patients who travel alone to four hours of continuous flight. But some may extend this limitation in individual cases. If a patient is unable to get about unaided, he may have to agree not to use the lavatory during the course of the trip.

Do wheel-chair and stretcher patients have to pay extra?

They pay only for the space they occupy. (This may mean two to four times the usual fare for the stretcher patient who travels by plane.) There's no charge for special loading and unloading service.

What help is available for transfer (say, from plane to train) or for overnight stops?

Some carriers arrange with other companies (an ambulance service, for instance) to provide the needed help. The Travelers Aid Society may be able to give assistance. The nurse should check with an intake worker at the local headquarters, giving information about the patient's social and medical situation. The worker may then make arrangements for help at the transfer point and the patient's destination.

So much for the usual questions the patient may ask. Here are some additional facts he may find helpful:

Airlines. Some provide a fork-lift service that hoists the wheel-chair or stretcher patient right up to the airplane door. Some provide narrow wheel chairs that can be pushed down the aisle of the plane.

Most airlines accept only those stretcher patients who can travel in a seat, thus meeting government regulations that require passengers to wear seat belts or tie-down straps. (The

patients may be carried on and off the plane.) A few lines transport patients on stretchers, but only on specially equipped planes. For example:

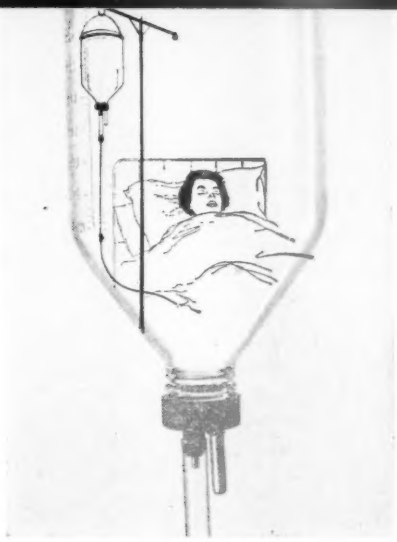
Some Pan American planes have seats that can be lowered into a prone position. A stretcher fits over two seats. Some Trans World Airlines planes can be equipped with a special pallet, with foam-rubber mattress and straps. This fits over four seats.

Wheel-chair and stretcher patients should arrive at the airport well before flight time, for they're taken aboard ahead of other passengers. At their destination, they get off last.

Medical supplies the patient needs during the trip (insulin and syringe, for instance)

Continued on page 72

"Mr. Hendrix, you're not cooperating!"



Some pointers on I.V. therapy

By Doris A. Brickman, R.N.

All nurses know that many patients are "needle shy." For such patients, any form of parenteral-fluid therapy is an ordeal.

This is one of the reasons I chose to make I.V. administration my specialty. It seemed to me that a specially trained, experienced R.N. could do much to relieve the discomfort of this experience. Now, after doing more than 10,000 I.V.s, I've found I was right.

Furthermore, I'm now convinced that *any* nurse—whether she assumes full or partial re-

THIS ARTICLE *has won a 1960* RN *Award for its author who is I.V. Nurse at Evanston Hospital, Evanston, Illinois.*

sponsibility for I.V. administration—can ease the patient's discomfort considerably. The following are pointers I've found helpful:

¶ Give the patient an adequate explanation of what you're doing.

This is elemental but important. Nothing upsets a patient more than to have the nurse confront him with a frightening array of tubing, solution bottles, and syringes without a word of explanation.

After introducing myself, I start my explanation at once—like this: "Because you can't eat, your doctor wants you to have food and fluids through one of your veins. We call this I.V. therapy. I'm going to give you needed food and fluids by means of the equipment I'm setting up now."

As I talk, I prepare my equipment quickly and with a minimum of display so the patient won't become tense. I ask him if he knows how an I.V. is given. If he says no, I explain it this way: "A hollow needle will be inserted into a vein. The fluid will run from this bottle, through the tubing and needle, into the vein."

Some patients become interested and want to know more. If so, I continue my explanation. I use nontechnical language to answer their questions. For instance, if the patient asks what's in the bottle, I may answer "Sugar and water" or "Vitamins and minerals" (depending, of course, on what has been ordered).

¶ Choose an appropriate needle. Consider (1) how long the therapy will continue; (2) the site; and (3) the condition of the vein. The needle selected with these considerations in mind will cause the least discomfort to the patient.

For therapy lasting twelve hours or less, I choose a standard 20-gauge, 1″ steel needle. (For a transfusion, I choose an 18-gauge, disposable steel needle.) There's one exception: If I expect to give the I.V. through a small vein (for example, in the hand or a finger or a toe), then I choose a pediatric scalp-vein needle.

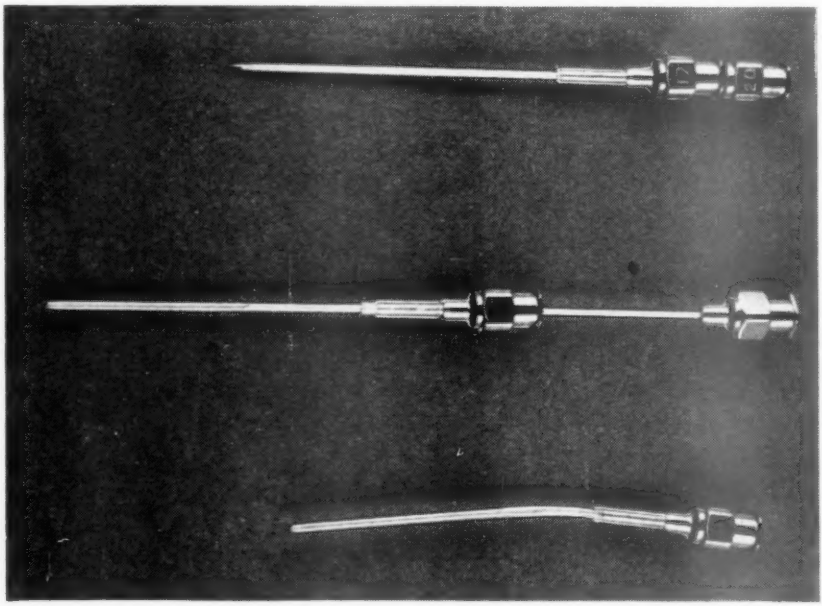
For therapy lasting more than twelve hours, I choose a 17- or 18-gauge plastic needle or a plastic catheter (see photos pages 40-43). This permits the patient more freedom of move-

ment than the steel needle. Also, with a plastic needle or catheter there may be no need to restrain his arm. (I have seen cases where an arm restrained on an armboard for a day was so stiff it took the patient three days to regain full use of it!)

Again, there's one exception: When the patient has poor skin turgor, I do not use the plastic catheter. Skin with poor turgor tends to stretch during the insertion; thus leaks may develop around the catheter.

¶ Choose a site that's safe, functional, and comfortable for the patient.

Sometimes I'm tempted to use the large, accessible veins in the antecubital area, especially when the veins of the lower arm



THE PLASTIC NEEDLE LOOKS LIKE THIS *(top) when its inner steel needle is in place. (Note the two hubs.) The steel needle acts as a stylet during insertion. Its tip projects about ⅛" beyond the plastic needle's tip. Next (center picture), the steel needle is partially withdrawn; finally (bottom picture), the plastic needle stands alone.*

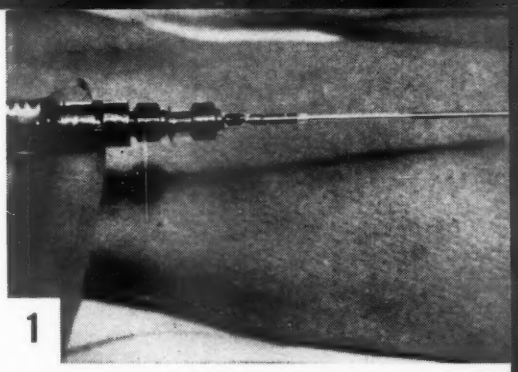
THE INSERTION PROCEDURE *includes these steps (top to bottom):*

First, the nurse, who has attached the hub of the inner steel needle to a syringe, approaches the anesthetized insertion site.

Next, she advances the needle into the vein. She aspirates blood (see the syringe) to check in-vein position. Note that the area around the insertion site has been shaved in preparation.

Third, she starts to withdraw the inner steel needle with the fingers of one hand. (Note that she touches only the hubs of the needle.) With the other hand (at rear), she steadies the patient's arm to maintain the vein in proper position.

Finally, she advances the plastic needle into the vein while continuing to withdraw the inner steel needle. When she has completely withdrawn the steel needle, she'll attach the I.V. tubing to the plastic needle's hub.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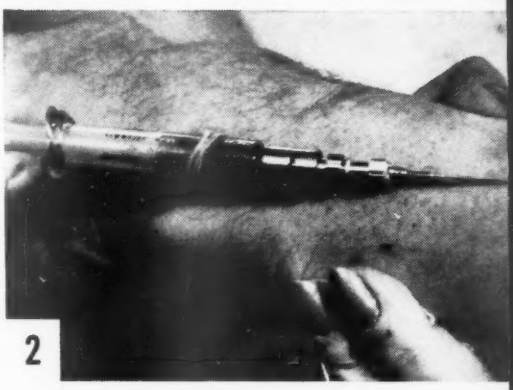
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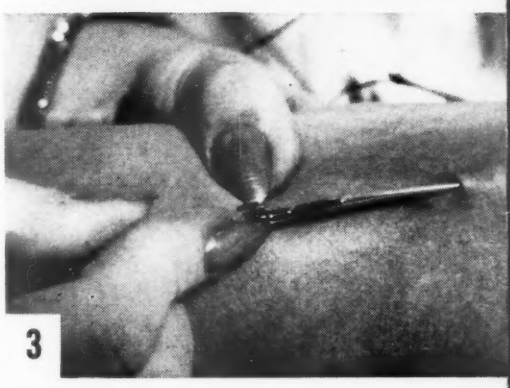
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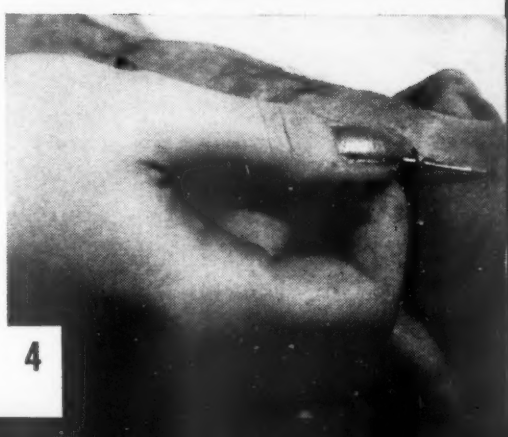
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have been exhausted by repeated venipuncture. Then I remind myself that if I used one of these veins:

1. I would have to extend and restrain the patient's arm in an unnatural position, adding to his discomfort.

2. Such use might exhaust a vein which could be put to better use for drawing blood specimens.

For short-term therapy with a steel needle, I choose a vein in the hand or the lower arm, if available. Otherwise I may use a vein in the wrist, the foot, a finger, a toe, or the upper arm.

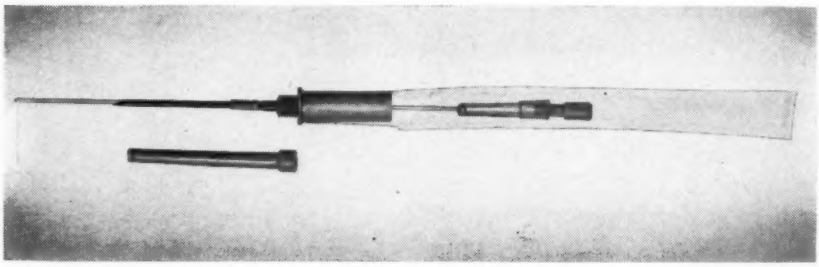
For long-term therapy with a plastic needle, I choose the cephalic vein in the upper arm, midway between the shoulder and elbow, if available. If not, I choose the cephalic vein in the lower arm, about one to two inches above the wrist. (Patients develop less reaction to the plastic needle when it's inserted in the upper arm.)

I bear in mind that I must not place the plastic needle in or near a joint because:

1. Joint flexion may force it against the vein wall, obstructing the fluid-flow.

2. Flexion also may weaken the plastic needle, causing it to break.

When using the plastic catheter, I usually choose a vein in the wrist or one just above the thumb. Occasionally I choose



THE PLASTIC CATHETER LOOKS LIKE THIS *when the protective cover for the needle has been removed. The catheter has been advanced through the needle and beyond its tip to show its position as it passes into the vein. A clear plastic sleeve (right) is attached to the needle's hub. The sleeve envelops the catheter and prevents contamination during handling.*

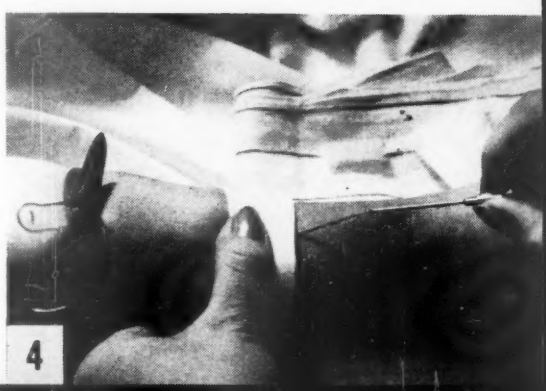
THE INSERTION PROCEDURE *includes these steps (top to bottom):*

First, the nurse, who has anesthetized the insertion site, inserts the needle into the vein. Blood flows into the catheter at right as it rests within the needle and the clear plastic sleeve.

Next, she advances the catheter three to four inches into the vein by handing it along through the plastic sleeve.

Third, she steadies the still-inserted needle with one hand, touching the hub only. With the other hand, she detaches the plastic sleeve from the hub, draws it over the catheter, and will discard it.

Finally, after placing a 2 x 2 over the insertion site and taping it securely, she applies digital pressure just forward of the site to anchor the catheter, while she withdraws the needle to the distal, flanged end of the catheter where it remains. She'll then attach the I.V. tubing to the needle's hub.



TEACHING *is as important an aspect of her work as skillful performance of venipuncture, says the author. Here she conducts an I.V. therapy class for other R.N.s. The subjects that are covered in class include such aspects of I.V. therapy as equipment, fluids, nursing care, and hospital policy.*

a vein in the antecubital area.

¶ Minimize local discomfort when inserting the needle.

I've found the following to be helpful:

1. If you choose a small or a hidden vein for venipuncture, have the patient hang his arm in a dependent position. Within five to ten minutes the vein will become distended and more clearly visible. (A hot pack will also help to distend it.)*

2. If you plan to use a plastic needle or catheter—both of which are large and somewhat painful to insert—inject subcutaneously beforehand one-half cc. of 1 per cent procaine.

3. If there's a heavy hair-

*For more about venipuncture technique see "Guides for Giving Injections," *RN*, January, 1960.

growth on the site, shave the area before insertion. Removal of the adhesive tape afterwards will then be less painful.

¶ Tell the patient exactly what movements are allowed.

If you do this, you usually will not need to apply an armboard or other restraint. However, your instruction must be specific for the type of needle used. For instance:

When I use a steel needle in the arm, I tell the patient he may move his arm toward or away from his body, or flex it slowly with care. I prohibit flexion, of course, if the needle is in the antecubital area.

I tell him *not* to rotate his arm or let it hang dependent for any length of time. If he's able to get out of bed, I show him how to flex the arm and support it against his midriff while he's moving about.

In contrast, suppose I insert a plastic needle or catheter. In that case I tell the patient there are no restrictions on his movements (within reason).

If the patient is an infant or is unconscious or unable to cooperate for some other reason, I choose a site that will allow him the most free movement. I use a plastic needle because of the freedom it allows. After I've inserted the needle, I cover it and the end of the attached I.V. tubing with tape. Finally, I roll stockinette over the entire area and tape the material at either end to the patient's skin.

¶ Check the I.V. frequently.

Inspecting the set-up frequently helps prevent obstruction and infiltration and may save the patient the discomfort of another venipuncture. I check such things as the solution bottle, flow rate, in-vein position of the needle, and the patient's reaction.

I'm especially careful to check for vein-reaction when I'm using the plastic needle or catheter. Vein reaction is evidenced by redness over the vein at the site of the catheter or needle, warmth of the tissues, swelling, and pain. Such reaction usually develops after three to fifteen days of continuous therapy. When it does, the needle or catheter must be changed to forestall a severe reaction.

¶ When removing the needle, strive for maximum vein collapse.

Exert pressure on the site as you remove the needle. If the

needle was in the arm, have the patient immediately hold his arm straight up (*not* flexed) with hand open (*not* made into a fist). This position is especially important if the needle was in a vein in the antecubital area. The pressure plus the arm position will promote prompt cessation of blood flow.

* * *

Foregoing are the most helpful techniques I've found in my work as an I.V. nurse. I will add three more pointers:

¶ If you're inexperienced in doing venipuncture and are asked to assume this responsibility, insist on adequate instruction and supervision. (I was thoroughly instructed in venipuncture technique by our staff of anesthesiologists before I assumed my responsibilities as I.V. Nurse. Also, I work under the direction of the patient's doctor, who indicates by written order the type, amount, and flow-rate of the parenteral fluid he wishes given. Instruction is especially important if your hospital uses the newer plastic needles and catheters. For if this equipment is misused, it can be hazardous for the patient.)

¶ Make sure of the legal interpretation of nursing practice in your state.*

¶ Practice doing venipuncture at every opportunity. Repeated performance is the best way to gain confidence and improve your skill.

As your skill grows, I'm sure you'll have the satisfaction of hearing many of your patients say, as you discontinue their I.V.s: "It wasn't bad at all."

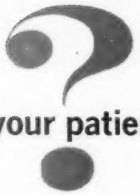
That is what makes me like my job! END

*Interpretations vary from state to state. In Illinois, where the author is employed, the R.N. is not specifically prohibited from carrying out I.V. therapy. She must do so, however, "under the direction of a licensed physician or dentist."

Inside information

A 14-month-old patient in our hospital was put on a nothing-by-mouth schedule and his nurse, as a matter of course, taped an NPO sign to his crib. Several hours later, we noticed bits of cardboard in the baby's stool. He'd eaten the sign!

—ROBERT B. ALLPORT, M.D.



When your patient asks:

'Will I always have this colostomy?'

BY ILSE WOLFFE, R.N., M.A.

Mr. Jones, a post-op patient, is doing well physically. But he seems nervous and depressed. Suddenly he asks: "Will I always have this colostomy?"

How do you answer him?

A recent *RN* survey shows how 200 nurses commonly react. Their answers go like this:

¶ "Probably," say 21 per cent. "But many people live comfortably with a colostomy."

¶ "Probably not," say 17 per cent. "A colostomy is often temporary."

¶ "I really don't know," say 10 per cent. "It takes time to find out if a colostomy can be closed."

¶ "You'd better ask your doctor," say the others.

Why do all these nurses give an answer that's either indefinite or evasive?

One reason is this: The patient's query puts a sensitive nurse on the spot. Her first thought is: "I don't dare to tell him the truth!" So she dodges the issue (or tries to), thus preserving her own peace of mind.

Meanwhile, what about the patient's peace of mind? Does

THIS ARTICLE *is the third in a series suggesting appropriate answers for a nurse to use when her patients ask difficult questions. The author is Mental Health Nursing Consultant to the Connecticut State Department of Health, Hartford.*

the nurse help to restore *that* when she gives an indefinite answer?

Possibly, for the moment—particularly if she adds a reassuring comment (such as "You'll find it isn't as bad as it now seems" or "Maybe it can be closed later"). But the effect doesn't last, simply because her answer *is* indefinite.

Suppose she says, "You'd better ask your doctor." The patient knows at once that her reply is evasive. He feels that he has been let down and his fear increases.

What, then, is the best way for a nurse to cope with this situation?

First, she prepares herself by asking the doctor (1) what he has told the patient, (2) what he wants the patient to know, and (3) what he thinks should be emphasized. (She also examines her own feelings about a colostomy.)

When the patient asks his question, the nurse doesn't answer him directly. Why? Because his question is indefinite: It doesn't tell the nurse exactly what's worrying the patient. For instance:

Is he afraid that a colostomy will make him unemployable? Is he worried about odor? About irregularity? Or is he afraid that his relatives and friends will consider him "repulsive" or look upon him as a "freak"?

"Only by getting the patient to 'talk out' his fears can a nurse really help him," says one astute R.N.

To gain time and better understanding of the question, this nurse uses a counter-question: "What makes you ask?" Or: "Did your doctor say you'd always have it?" Or she uses a questioning statement: "This seems to worry you?" Or: "This is uppermost in your mind?" By encouraging the patient to clarify his question, she not only shows that she's truly interested in his welfare; she also helps him to identify the particular aspect of the colostomy problem that seems to trouble him most.

Once a nurse discovers the underlying cause of her patient's concern, she can respond intelligently and helpfully. What she says will, of course, depend upon the circumstances. The *way* she says it (that's what counts the most) will convey this basic thought:

"You can be sure, Mr. Jones, that your doctor will close the colostomy if it's humanly possible to do so. If he can't close it, you can still live a productive, satisfying life as thousands of other people with a colostomy do. And, if you'll let me, I'll try to help you."

That is the kind of positive reassurance the patient really wants. END

Tuition-paid short courses may be open to you

Want to update your skills in administration or supervision or teaching? The short-term courses given under the Professional Nurse Traineeship Program of the Department of Health, Education, and Welfare may be your answer. These provide tuition and fees, plus $12 a day allowance if you need to leave home to attend.

To be eligible, you must be an R.N. who's employed in one of the above fields, or who has a commitment to enter one of them. Other requirements: citizenship (or first papers) and graduation from a state-approved nursing school.

A number of courses on a variety of subjects are offered under sponsorship of universities, hospitals, boards of health, and professional nursing associations. Courses vary in length from five days to a month.

Now's a good time to look into the 1962 program. To start, write to the Division of Nursing, Public Health Service, Washington 25, D.C. Ask for a list of agencies sponsoring short-term courses. Next, write to the institution which has the course you want to attend, requesting an application blank. Finally, get a recommendation from your employer and send it with your application. The institution will judge your qualifications and award, or refuse, a grant. END

'I want to nurse

my baby, but—'

BY DOROTHY PATTERSON GAULT, R.N.

Mary L—, the 18-year-old in the next bed, fell back on her pillow, exhausted after a ten-minute attempt to persuade her sleepy newborn to nurse. Wiping perspiration from her brow with a corner of the sheet, she said, "Before the baby came, I thought it might be kind of nice to nurse her. I read this article that told how good it was for the mother and child. Now I'm not so sure."

She went on wistfully: "She doesn't seem to catch on, and I *am* pretty small. Maybe I wouldn't have enough milk anyhow . . ." Her voice trailed away in a fog of indecision.

I was sitting in a chair, waiting for my husband to take me and my 4-day-old son home. "Look, Mary," I began, "the size of your breasts doesn't have anything to do with—"

Just then a new nurse bustled in inspecting her high-hemoglobin-red fingernails for chips. She picked up Mary's still-slumbering infant and started out.

Hesitantly, Mary called after her: "I couldn't get her started, Nurse."

The R.N. paused in the doorway. "That's all right," she said airily. "We'll feed her in the nursery. She'd just get colostrum from you anyhow." She disappeared, leaving Mary feeling not only inadequate but also puzzled by the clinical term.

In the flurry of leave-taking, I didn't have a chance to do

more than wish my neighbor luck and say good-by. I hoped that some R.N., more objective than the nail-examining one, would take a few moments to explain the meaning of "colostrum" and encourage Mary in her wavering desire to feed her baby the natural way.

As a graduate nurse and as the parent of both a 3-year-old and my new arrival, I viewed the situation from two sides. I could still recall the 2 P.M. rush to get the proper babies to their respective mamas, shoo stray visitors, feed the preemies, and reassure the distraught mother in 202 that junior's circumcision had been uneventful. On the other hand, I knew exactly how mothers feel after the big production: marvelously flat in the midriff and eager to do the right thing by this new scrap of humanity, just introduced to the world.

I realized how decisive a factor the maternity nurse's attitude can be in influencing mothers on the question of breast feeding. Many mothers are ill-informed about or ignorant of the important aspects of this subject. In these fast-paced days, the busy obstetrician or general practitioner often has neither the time nor the on-the-spot opportunity for counseling that the nurse has.

"Agreed," you may say. "But let's be specific. Just *what* can we nurses do to help the new mother who tries breast feeding?"

The following are a few of the ways that seem important to me on the basis of past experience. I'm sure you can think of others.

¶ First, help dispel the mother's misconceptions.

As in the case of Mary L—, the misconception that pin-up proportions are required to insure an adequate milk supply is a common one. Your assurance that this isn't true will do wonders in dispelling the doubts of those whose measurements fall short of prevailing Hollywood standards.

A mother also may worry about the effect the nursing period will have on the subsequent shapeliness of her bosom. Perhaps somewhere in her past an elderly obese person blamed a sagging facade on the fact that she nursed her youngsters. A gentle reminder that pendulous

Continued on page 78

What you can do about HEAT STROKE

By Sister Michael Marie, M.D.

It's a broiling summer day. You wish you were anywhere but at work. As you pass from room to room with medications, you feel sorry for the sweating patients. A good-natured patient hastily draws his exposed feet back under the sheet when you approach. He says with a grin: "Boy, it sure is hot!"

On your way back to the nurses' station, you meet the new admission. You stop by the stretcher to greet her. Your practiced eye tells you she's acutely ill. But her flushed skin puzzles you. It seems inconsistent with the diagnosis the admitting office gave you—cerebral vascular accident. You glance at the admission notes: temperature, 105.6° F.!

* * *

As illustrated by the above example, the diagnosis of heat stroke is often missed. Many times heat stroke is confused with C.V.A. because clinically the signs are similar. But, as also illustrated, there are usually two symptoms not commonly presented in C.V.A.: a soaring temperature (105° F. or above) and a flushed skin that's hot and dry.

The nurse can help pinpoint

THE AUTHOR *is physician-in-charge at Mercyknoll, a home for aged religious, in West Hartford, Conn. She is a member of the Order of the Sisters of Mercy.*

heat stroke by being alert to the following:

1. Elevated temperature in obese and elderly persons (those over 65, especially).

2. Severe headache, anorexia, and malaise.

3. Lack of sweating despite the heat.

4. Flaccid paralysis and abnormal central-nervous-system signs. (These in particular can be misleading; for they seem to point to C.V.A.)

Heat stroke is commonest, of course, during summer heat waves that last several days, when the temperature may be 95 or more, with high humidity and no breeze. Under such conditions, elderly, obese persons in hot, airless rooms readily succumb.

But heat stroke may occur at any season—brought on by internal disturbances (for instance, hyperpyrexia in the elderly due to pneumonia).

To understand why this is so, let's review briefly the body's temperature control mechanism.

The heat-regulating center is in the hypothalamus. When normal body temperature begins to rise because of external heat, or because of stepped-up metabolic activity (as when the body is fighting infection), the center sends neural impulses to the lungs, sweat glands, and arterioles. Respiration steps up and the sweat glands increase their secretion. The arterioles dilate, allowing more blood to circulate near the skin's surface. Increased evaporation and heat radiation through the skin help lower the body temperature.

But suppose something prevents heat dissemination—for example, suppose the sweat glands don't function properly. Then the body temperature continues to rise. This further stimulates the heat-regulating center. Under excessive stimulation, it fails. The temperature then rises unchecked. Ultimately, the vasomotor centers are damaged, vascular collapse occurs, and the patient dies of a temperature exceeding 110° F.

To help prevent this sequence of events, you'll want to be particularly alert for rising temperatures in the following patients:

Those receiving belladonna-like medications. Such drugs, because of their ability to depress secretions, may prevent sweating.

Those going to surgery. Such patients may have received belladonna-like medications (atropine, for example). In the O.R. they'll be swathed in drapes that prevent sweat evaporation.

Postoperative patients. Their heat regulating mechanisms may be damaged during surgery. Usually the O.R. or the recovery room, or both, are air-conditioned. So these patients may not show signs of impending heat stroke until a day or two after they've been returned to their own non-air-conditioned rooms. Here, their rising temperatures may be attributed to postoperative infection.

Elderly, chronically debilitated patients (when bedfast, especially). Patients with Park-

legal pointer

QUESTION: *I've been subpoenaed to testify in court concerning the medical record of a patient. As a nurse, should I confine my testimony to certain parts of the record?*

ANSWER: Yes. As an ordinary witness, you're obliged to testify only as to the notes and records you've personally made or those made by other nurses under your supervision and acting by your direction. These are a part of the nursing-service record. You may refuse to testify to any other parts of the medical record—for instance, the medical progress notes, pathology and radiology reports—because these matters involve *medical* judgment.

DO YOU HAVE A QUESTION *about some legal aspect of nursing? If so, send it to William A. Regan,* LL.B., *care of* RN. *He'll select questions for reply on the basis of their general interest to readers. No questions can be acknowledged or returned.*

inson's disease, for instance, are prone to heat stroke because of damage to the basal ganglia. Over-clothed beds or hot, airless rooms may start such patients on the physiologic road to heat stroke.

So much for being alert to the conditions favoring heat stroke.

The nurse can play a key role in heat-stroke therapy, too. Here, speed is imperative. The longer the patient's temperature remains near or above 105° F., the greater the possibility of irreversible brain damage and death. Even a few hours' delay may leave the patient with severe neurologic deficits.

When a temperature reaches a critical point, anticipate the doctor's order and start preparations. If it's nearing 105° F., prepare an ice-water bath or an ice-water colonic lavage. (The lavage may be used when a tub isn't available; but the effect is not as lasting as an ice-water bath.) If the temperature reaches 105° F. before action can be taken, prepare an ice-water bath.

Do *not* wait for orders for an antipyretic or waste time trying to locate a hypothermia blanket. Though both are effective in reducing body temperature, neither reduces it rapidly enough in these two situations.

Once you receive the doctor's order and begin treatment, you'll remain with the patient. An ice-water bath, or a colonic, is a drastic procedure. The patient can rapidly become hypotensive. So you'll watch him closely for signs of shock. (Ideally, a special nurse should be assigned to the patient.)

The seriousness of the situation calls for the doctor to remain with patient and nurse during the treatment. You'll be wise to insist on this, if necessary. Here's why: You'll have to (1) reassure the patient, if he's conscious; (2) check his temperature every five minutes; (3) check his pulse; (4) check his blood pressure, if indicated. Obviously, you can't do all those things at the same time!

You'll take the temperature orally during treatment. (You'll bear in mind that an oral temperature is one degree lower than a rectal.) You know that if the patient is mouth-breathing, the oral temperature may not be accurate. However, the situation is so serious that you'll make allowance for this.

Five to twenty minutes after the patient enters an ice-water bath, or an ice-water colonic is started, his temperature usually falls to a desired 101° F. He then begins to show signs of improvement. He's more alert. If he had a slight paralysis, it disappears. He usually volunteers the information that he feels better.

He can then be removed from the tub, or the colonic can be terminated. The doctor usually orders an antipyretic (aspirin suppositories, for example). He may also order vasopressors. If he started I.V. fluids to prevent hypotension during hypothermia, he may wish them continued.

Hypotension may occur several hours after treatment. So you'll check the patient's blood pressure regularly during the next twenty-four hours. You'll check the temperature also. If it begins to rise (and it may because the thermal regulator is damaged), hypothermia may be repeated.

Clearly, heat stroke is a true medical emergency. Patients admitted to the hospital in coma have a poor prognosis. They may have residual damage, such as impairment of motor function and mental ability. Some die despite our best efforts. As for other patients: Their prognosis depends on such factors as age, obesity, general health, condition on admission, etc.

For those who respond to in-

Blueprint for a millennium

When the patient's not impatient or demanding,
When the family isn't ditto—or perverse,
When the doctor's on the ball and understanding,
When the aide is really aidful to the nurse,
When the supervisor isn't super-bumptious,
When a hypo makes a youngster whoop with glee,
When the cafeteria food is hot and scrumptious,
Oh, *that'll* be the day for you and me!

—ANNA GRAY, R.N.

tensive treatment, proper after-care is extremely important. You'll protect such patients from exposure to heat. You'll see that their rooms are well ventilated and that they're not over-clothed. (Remember, these patients aren't able to sweat for twenty-four to forty-eight hours after intensive treatment. It may be six months before they begin to sweat normally.)

Also, you'll guard them against such complications as hypostatic pneumonia, decubitus ulcers, and kidney infection. The first two are common to elderly, debilitated patients. Frequent turning helps prevent hypostatic pneumonia. Meticulous skin care and careful handling, avoiding sheet-friction burns, help forestall decubitus ulcers. Cautious catheterization and scrupulous care of the drainage set-up help keep down the kidney-infection rate.

What can you do to help reduce the danger of heat stroke? Here are some suggestions:

¶ Advise the elderly, the obese, the chronically ill—and especially persons taking belladonna-like medications—to be careful about exposure to heat. Suggest that they keep their rooms well ventilated during hot weather, use fans or air conditioners, and take frequent cool baths.

¶ Urge relatives and friends to take measures to avoid prickly heat; for prickly heat damages the sweat glands. Preventive measures include the use of air conditioners; wearing loose, porous clothing; and taking frequent baths or showers *without* soap.

¶ Advise those who have lived in a hot, dry climate for some years to be alert for early signs of heat stroke—for example, malaise, anorexia, and lack of sweating. Tell them that prolonged exposure to heat may damage the sweat glands and thus affect the body's ability to regulate its temperature.

¶ Protect your hospitalized patients—especially medicated, draped preoperative patients and debilitated bed-fast patients—from being overheated.

¶ Be suspicious of a climbing temperature (103° F. or over) that can't be traced to an infection and report it promptly.

As a nurse, you *can* do a great deal to help the patient with heat stroke. END

What you need to know about endometriosis

By Charlotte Isler, R.N.

You're probably aware that endometriosis has increased significantly during the past ten to fifteen years. As you've read this diagnosis on charts and pathology reports of an increasing number of patients, you may have realized suddenly that you, too, may be a candidate for endometriosis.

Where do we stand today in our knowledge of the cause of and cure for this painful affliction that's described as "a benign disease with malignant characteristics"? To find out, I interviewed Dr. Robert W. Kistner, associate in gynecology at the Harvard Medical School and a recognized authority in this field. My questions and his answers follow:

What causes endometriosis?

Particles of endometrial tissue (the mucous membrane that lines the uterus) become lodged in other areas of the body. Here they continue their growth. They "menstruate" when stimulated by the hormones that stimulate the endometrium. If there's no outlet for this menstruation, the blood and cast-off menstrual tissue may cause tissue-destruction, scarring, and fibrosis. This may

happen in the ovaries, tubes, vagina, cul-de-sac, and the serosa of the rectosigmoid.

How does endometrial tissue get into such areas?

The most widely accepted theory is this: During the menses, viable fragments of the endometrium are included in the menstrual flow. Some are regurgitated through the oviducts and become implanted on the ovaries or in the cul-de-sac.

Occasionally, functioning endometrial tissue may be found in the pelvic lymph nodes or far removed from the pelvic area—for instance, in the pleura, lungs,

---

Decompression dome speeds childbirth

This patient-operated plastic dome developed at St. Mary's Hospital in Montreal is said to reduce pain and speed the first stage of labor. Here OB Supervisor Margaret Howard watches a patient use it.

When a contraction starts, the patient pushes the button-switch in her left hand. This starts a tank-type vacuum cleaner that's placed on the floor at the bedside and attached to the dome by a hose. The cleaner sucks air from the dome, creating a vacuum. The vacuum draws the patient's abdominal muscles away from the uterus during the contraction, thus relieving pain.

To control the amount of vacuum, the patient watches a gauge set at eye level on the dome. (Her eyes are blanked out here to hide her identity. They are not bandaged.) If the contraction becomes severe, she increases the suction by turning a valve with her right hand. After the contraction ends, she switches off the vacuum cleaner.

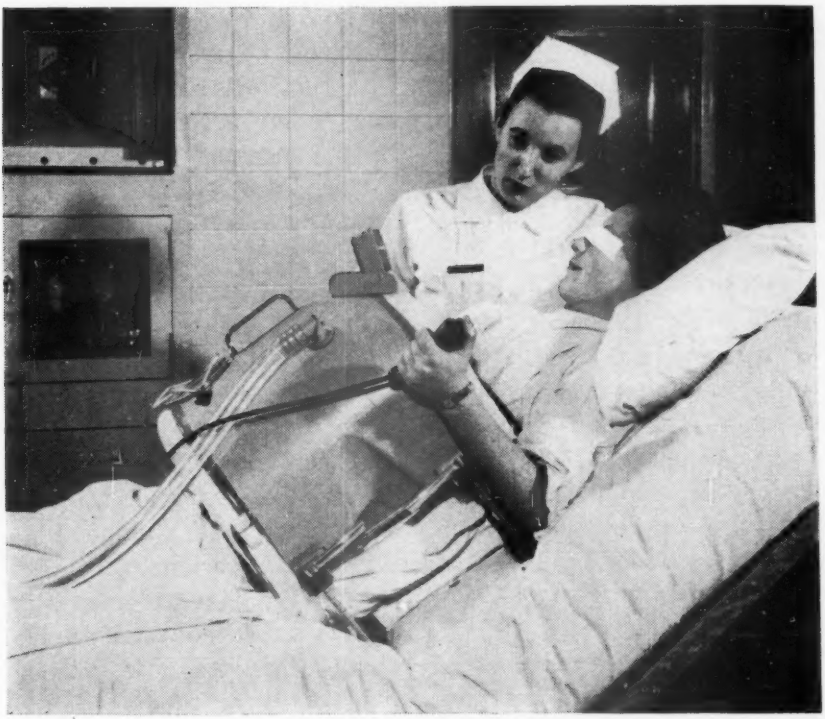
Of the first thirty-one patients who tested the dome, twenty-eight reached full dilatation in less than five hours, says the hospital's OB team. Most reported substantial pain relief; only seven needed sedation. END

arms, and thighs. These fragments probably are disseminated through lymphatic or vascular channels.

Another theory: The tissue that covers the pelvic peritoneum and the ovaries is embryonic tissue (coelomic epithelium) left over from the formation of the vagina, uterus, and tubes. Recurrent menstruation is thought to stimulate this tissue to undergo changes (metaplasia) and become functioning endometrium.

Does this mean that all women are susceptible?

Theoretically, any woman



who has menstruated and ovulated for more than five years without interruption may develop it. Women who don't ovulate and those who've completed the menopause aren't susceptible. The highest incidence is among women in their late twenties and in their thirties who belong to upper-income families and those who work at a professional or career level. This includes nurses.

Why are career women particularly susceptible?

Because these women—including nurses—usually have fewer children than those in low-income groups; and they have them later in life.

You mean, then, that early and frequent childbearing prevents endometriosis?

Often. Here's why: Pregnancy brings a temporary halt to ovulation and menstruation. It also brings an increase in the secretion of ovarian hormones. These two factors produce atrophy of endometriotic areas. They also suppress the development of new lesions.

How common is endometriosis?

As many as 30 per cent of women may have it. The incidence is increasing today as more women in the higher-income groups defer marriage or put off childbearing because of their careers.

What are the symptoms of the disease?

These are the most common: (1) pain just prior to or during menstruation, becoming more severe each month; (2) painful defecation, especially during the menses; (3) premenstrual staining, or excessive bleeding during menstruation; (4) menstruation which lasts too long; (5) urinary frequency and hematuria, especially when they occur at intervals related to the menses.

The doctor verifies his diagnosis by visual examination of the pelvic viscera through an endoscope (culdoscopy). He also takes biopsies of suspicious areas.

How is endometriosis treated?

That depends on its severity. In mild cases, analgesia may be sufficient, with continued observation. Occasionally a patient "outgrows" her endometriosis. If she's a married woman in her childbearing years, we recommend early pregnancy, with fre-

quent subsequent pregnancies.

If the endometriosis is extensive, causing severe local symptoms or infertility, a conservative operation may be necessary. Diseased portions of the pelvis are resected; adhesions of the uterus and tubes are freed, then brought into correct anatomic position to facilitate conception. As much ovarian tissue as possible is preserved so that the patient continues to ovulate.

This is not considered a cure. As long as any part of either ovary is left in place, endometriosis can recur. But conservative surgery relieves symptoms and increases the chances for conception.

What other treatment is available?

In certain cases we use hormonal therapy. We administer, in gradually increasing amounts, the same ovarian hormones the placenta would secrete if the patient were pregnant. This creates a pseudopregnancy. Ovulation

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Mazola Corn Oil is unexcelled in polyunsaturates and lowest in saturates of all leading brands of vegetable oils. Mazola's P/S ratio is far higher than that of any other leading food oil. Your patient will find Mazola Corn Oil ideally suited for salad dressings and frying; also for baking wherever *liquid* shortenings are called for in the recipe.

Mazola Margarine contains *liquid* Mazola Corn Oil as a major ingredient. This corn oil is not hydrogenated, thereby preserving its rich content of linoleates. Mazola Margarine contains 2 to 3 times as much natural linoleates as any other margarine readily available in grocery stores from coast to coast. Its taste, color and handling characteristics are unexcelled.

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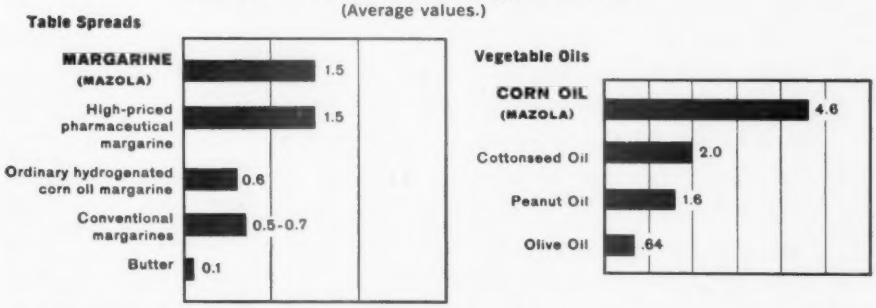
(All figures are in grams.)

	MAZOLA MARGARINE		MAZOLA CORN OIL	
	100 grams	2 oz. (4 tbsp.)	100 grams	1 fl. oz. (2 tbsp.)
Fatty Acids				
Polyunsaturated	21	12	51	14
Monounsaturated	40	23	32	9
Saturated	14	8	11	3
Natural Sitosterols	0.5	0.3	1	0.3
Natural Tocopherols	0.08	0.045	0.08	0.020
Cholesterol	none	none	none	none
Sodium	0.9	0.5	none	none

MAZOLA MARGARINE—410 Calories/2 oz.; Iodine Value—96
MAZOLA CORN OIL—250 Calories/fl. oz.; Iodine Value—124

RATIO OF POLYUNSATURATES/SATURATES
(Average values.)



CORN PRODUCTS COMPANY 10 East 56th Street, New York 22, N.Y.

and menstruation stop. So does their aggravating effect upon the endometriotic areas.

We've found pseudopregnancy especially helpful for (1) patients who have vaginal endometriosis, (2) those who need but refuse surgery, and (3) those who have recurrences following surgery. We also use it in selected cases as an adjunct to surgery.

What is a typical regimen?

Let's consider a woman who has extensive endometriosis. We start her on a daily oral dose of 2.5 mg. of Enovid, a drug that contains progesterone and a small amount of estrogen. At two-week intervals we increase the dose to 5 mg., 7.5 mg., and so on to 20 mg. daily.

Just as in a real pregnancy, the patient may at first experience nausea, vomiting, and breast soreness. To help control this, she takes the drug with milk or an antacid, or with her evening meal, or before retiring. After a few days her appetite generally picks up and she develops a sense of well-being. If she gains weight, we check her for water retention. When this is a problem, we put her on a low-sodium diet or prescribe a diuretic.

How long do you continue the therapy?

Usually at maximum dosage for at least six months, under close observation. Gradually her uterine endometrium and the endometriotic areas begin to change as they would in real pregnancy. After about three months, the scarred areas soften. Within six months these tissues may necrose and gradually be absorbed.

When she shows satisfactory improvement, we stop the drug abruptly. Four to six days later, withdrawal bleeding starts. In about six weeks, the patient has her first ovulatory menstrual period.

Because of the softening effect of hormonal therapy, we often use it preceding conservative surgery. After surgery, we may continue it for three months or so to provide additional rest for any endometriotic areas that may remain.

How successful is pseudopregnancy?

About 85 per cent of our patients show marked improvement. For patients who've had hormonal treatment following surgery for infertility and endometriosis, the fertility rate is

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See how it takes the work out of white shoes!

Hurry! We'll pay you 25¢ (see instructions in coupon) to discover how new Shinola White "deep-cleans" as it whitens . . . so shoes get white faster, stay white longer. New anti-rub-off formula . . . won't crack, chip or peel! Offer limited!

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encouraging. About a third to a half become pregnant, often during the second to fourth ovulatory period after treatment ends. Previously, pregnancy following surgery alone didn't occur until 2.7 years later, on the average, in our cases at the Free Hospital for Women.

Do you use hormonal therapy for women past the childbearing age who still menstruate and have symptoms of endometriosis?

Yes, preoperatively. If the patient definitely has passed the childbearing age and if her endometriosis is extensive, we give Enovid to soften the scarred tissues. Then we perform a hysterectomy and a bilateral salpingo-oophorectomy, also referred to as castration, to cure the endometriosis. Occasionally this radical surgery is performed on a younger patient if no other treatment has proved helpful.

What untoward effect does the surgery have on the patient?

It causes a surgical menopause. The patient may suffer hot flushes, sweats, and nervousness due to sudden, acute estrogen deficiency. Also, there may be changes in blood vessels and liver, and osteoporosis may develop. To alleviate menopausal symptoms, we start the patient on estrogen in small amounts from the fourth or fifth day postoperatively. Estrogen is continued for several years, then gradually terminated.

When estrogen is given for a long period, isn't cancer likely to develop?

Nurses often ask this question. There's no evidence that continued estrogen therapy encourages the growth of cancer in humans. But these small doses *do* make a tremendous difference in comfort for the patient.

What advice do you give women who come to you?

Many of them are worried about cancer of the cervix. We tell them they're much more likely to have endometriosis than cancer; for cancer affects only about 2 per cent of women.

We suggest an examination every three to six months. We point out that endometriosis is enigmatic. Some women have severe pain, but the doctor can't find extensive endometriosis. Other women don't

Oatmeal makes the patient feel "at home"

Naturally nutritious oatmeal is high in protein... high in thiamine

Quaker Oats and Mother's Oats are the same fine product.

Oatmeal is an ideal food for hospitalized patients, providing more protein than any other whole-grain cereal. Oatmeal with milk contributes substantially to the dietary allowances recommended for thiamine, riboflavin, niacin and iron. Rich in phosphorus, low in sodium, it is unsurpassed in dietary usefulness.

Oatmeal is easy to prepare... and economical to serve. It's high in nourishment... low in calories, even with milk.

One ounce of Quaker Oats provides the following percentages of adult M.D.R.: thiamine (vitamin B_1) 16.5%, phosphorus 16.5%, and iron 11.0%. Each ounce also provides 110 calories, and 16.7% protein, 6.9% fat, 62.4% carbohydrates, and 1.5% non-nutritive crude fiber.

For additional information write: Medical Service Dept.

The Quaker Oats Company

CHICAGO 54, ILLINOIS

have any symptoms, but the doctor can feel the presence of lesions. We point out that it's possible for a mild case to progress rapidly to the point of obstruction, perforation, and hemorrhage even while the symptoms remain slight.

To the married woman who shows signs of endometriosis, we say: Have an early pregnancy. Don't defer childbearing, even if this will interfere with your career. If you do, endometriosis may progress to the dangerous point where it causes sterility.

How can nurses help in the fight against this disease?

They can alert patients and friends and, at the same time, dispel false fears. For instance, some women think tampons cause endometriosis by preventing menstrual blood from being discharged through the cervix. This isn't true. By knowing the facts about the disease and passing them on, nurses influence many women to go to their doctors for regular check-ups. This in itself helps reverse the upward trend of endometriosis. END

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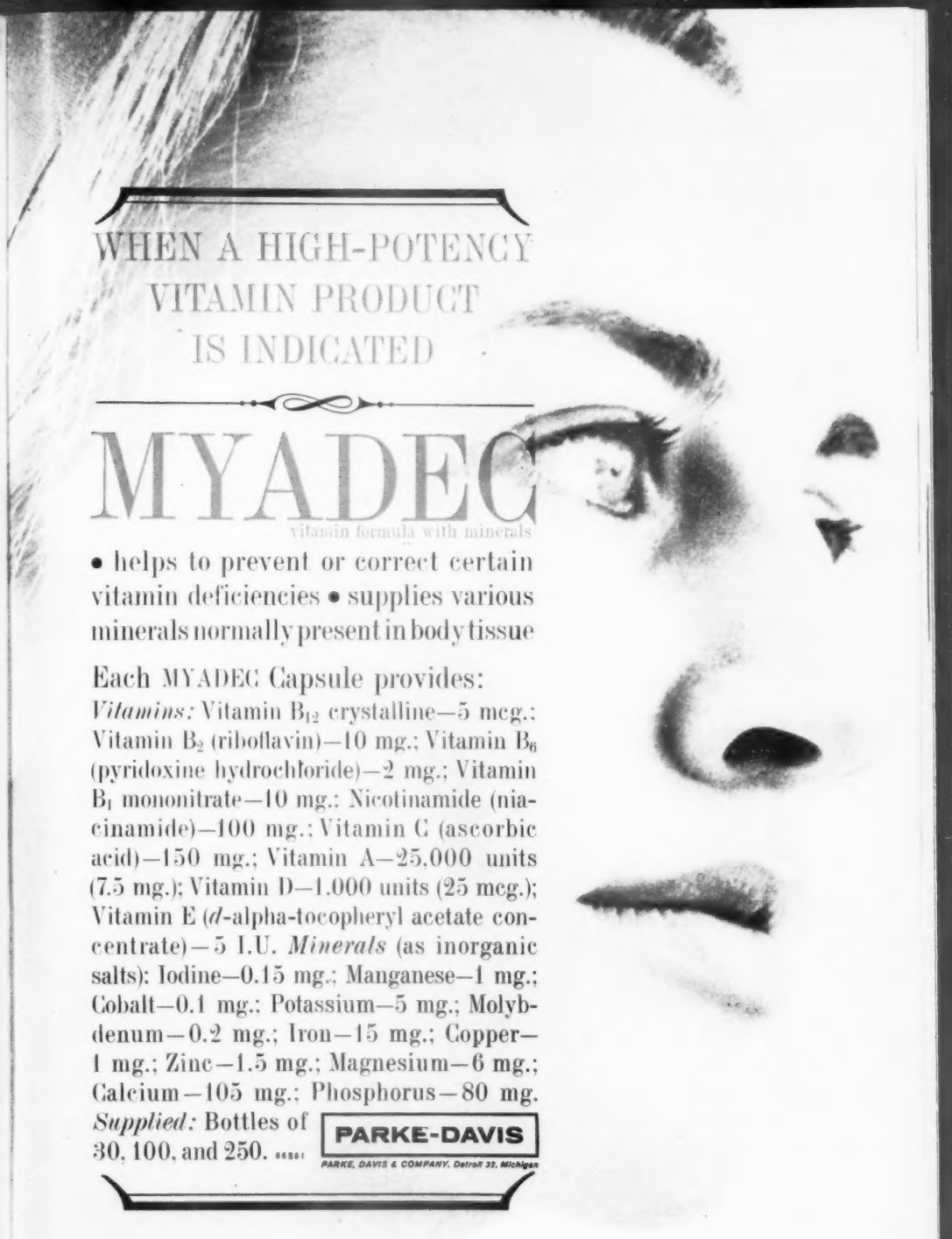

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Supplied: Bottles of 30, 100, and 250.

PARKE-DAVIS

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When your patient must travel by plane or train

Continued from page 37

should be carried in a hand kit. His other baggage is inaccessible during the flight.

The patient should be prepared for a last-minute refusal which, though rare, sometimes happens. The passenger-service agent at the airport and the plane captain have a right to refuse him space if they decide that a particular flight may be dangerous for him. A case in point:

At New York's Idlewild Airport, a stretcher patient suffering from a slipped disc was turned down at the last minute. Reason: Turbulent weather was reported along the route, signaling probable pain for the patient.

Railroads. The wheel-chair patient can count on the help of a Red Cap who will also provide a wheel chair if needed. At the train, porters help patient and chair aboard and transfer the patient to his seat. (There's no charge, but tips are appreciated.)

At a terminal where trains enter on different levels, the wheel-chair or stretcher patient may be taken to the proper level on the baggage elevator.

Most passenger cars have a special window for loading and unloading stretcher cases. Removing the window, putting the patient aboard, and replacing the window takes about fifteen minutes. Railroad workers remove and replace the window. Ambulance attendants handle the stretcher, assisted by the porters. END

nsect-inside

A 3-year-old boy was brought into the emergency room of our hospital after swallowing some insect killer. When asked why he drank it, he replied simply: "I ate a spider."

—BARBARA NIEMI, R.N.

Announcing the 1961

RN AWARDS

for original articles written by registered nurses

$150 for the one article adjudged the best of those submitted

up to **$100** for all other articles found acceptable for publication

You may write on *any* subject—preferably from your *own experience*—that you feel other nurses would like to read about. Looking through past issues of *RN* will help you get ideas. Examples of such ideas:

- ¶ How you (or a nurse you know) have successfully coped with a personal problem related, for example, to your pay or your professional advancement or your working conditions;
- ¶ A nursing technique or method you've learned that other nurses would find helpful;
- ¶ Some unusual and worthwhile step your local (or other) nurses' group has taken to help the nursing profession;
- ¶ An experience with a patient that inspired you or taught you something;
- ¶ What it's like to work in a particular nursing specialty or to nurse in an unusual situation.

Your article will have the best chance of winning an Award (a) if it's chock-full of *specific examples, cases, anecdotes, and experiences;* (b) if it refrains from preaching or lecturing to the reader; (c) if it's written conversationally and simply yet colorfully; (d) if it keeps within 1,500 words.

* * *

Entries must be postmarked no later than September 30, 1961, and addressed to Awards Editor, *RN*, Oradell, N.J. Manuscripts should be typed, double-spaced, on one side of the paper, and accompanied by a self-addressed, stamped envelope.

All manuscripts will be acknowledged, but those rejected may or may not be returned until after the close of the contest. *RN*'s editors will be the judges; their decisions will be final.

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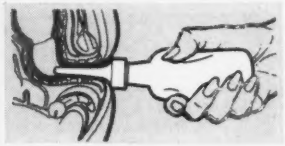
Pre-lubricated, anatomically correct 2-inch rectal tube avoids injury

Check valve regulates flow

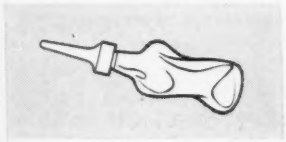
4½ fl.oz. of precisely formulated solution provides quick, thorough cleansing without patient discomfort

Compact squeeze bottle unit — no loose or moving parts

1. ***Ready to use*** ... no preparation necessary ... just remove protective cover



2. ***Easy to administer*** ... by nurse or patient ... takes less than a minute ... just squeeze bottle with one hand



3. ***Disposable*** ... simply discard unit after use ... eliminates cleanup and sterilization

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100 cc. contains: 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in 4½-fl.oz. squeeze bottle. *Pediatric size,* 2¼ fl.oz. *Also available:* Fleet Oil Retention Enema, 4¼-fl.oz. ready-to-use unit containing Mineral Oil U.S.P.

WHAT'S NEW IN *Drugs*

Claims made here for new drug products are claims made by the manufacturers of those products and reported in this column as a service to readers. RN *itself makes no product claims. For complete information on indications, dosage, side effects, etc., see the manufacturer's directions for each product.*

Bowel tranquilizer: Infants and children with acute diarrhea have had their severe symptoms relieved by thihexinol methylbromide (*Entoquel*), a drug in syrup form that promptly halts excess intestinal motility. Side effects have been rare, though some youngsters have shown mild skin flushing. Caution is needed when giving the drug to older patients with conditions that might be harmed by atropine-like action.

Respiratory stimulant: Breathing difficulty in barbiturate overdosage and other drug-induced respiratory depression is overcome by the administration of ethamivan (*Emivan*), a new nervous-system stimulant. Given by I.V. injection, the drug soon restores

normal breathing and rouses comatose victims of depressant drug intoxication. Given orally, it helps patients with chronic respiratory difficulties to breathe better. It's believed to speed carbon dioxide removal from the lungs and prevent respiratory acidosis.

For blood cholesterol: Sodium dextro-thyroxine (*Choloxin*) lowers high blood-cholesterol levels without speeding up the general metabolic rate. This new synthetic thyroid drug reduces plasma lipids much as the natural thyroid hormones do. But it's free of the side effects they can cause.

Unlike levo-thyroxine, Choloxin has had no undue effect on cardiac action. This should make it especially valuable in attempts to reduce the blood cholesterol of patients with atherosclerosis of the coronary arteries.

—MORTON J. RODMAN, PH.D.

Erratum

"Drugs for Diabetes Treatment" in *RN*, June, 1961, listed Globulin zinc insulin, U.S.P. (Globulin Insulin with Zinc). This should have read: Globin zinc insulin, U.S.P. (Globin Zinc Insulin).

'I want to nurse my baby, but—'

Continued from page 52

breasts are a result of overweight and lack of proper exercise is usually sufficient to dismiss such fears.

¶ If the patient needs help with the first feedings, give her that help.

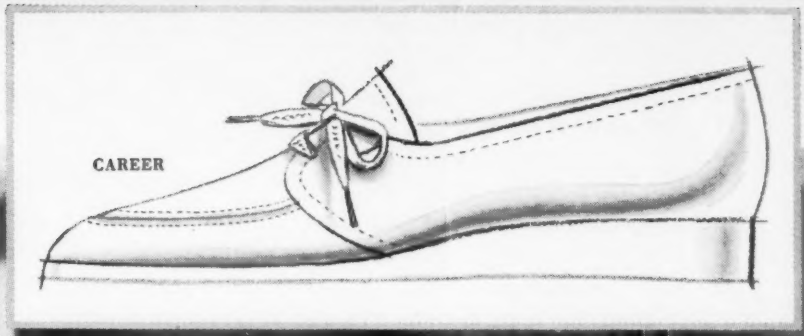
The mother who has undergone a prolonged labor and difficult delivery, or whose infant is lethargic, may require such assistance. Trying to rouse a baby who acts as though he'd stayed up for the late, late movie can be an exhausting and frustrating experience for her.

Personally, I shall never forget the alert nurse who first discovered my baby was futilely attempting to suck with his tongue cleaving to the roof of his mouth. From then on she always made sure he was properly started before she left us alone.

¶ Help calm the mother's fears.

The R.N.-patient who is wrinkling a maternity-bed drawsheet instead of straightening it for someone else is impressed by the gravity most patients attach to remarks made by the nurse. Off-hand observations such as "Your baby doesn't seem quite satisfied" or "My, your milk looks blue" may take on distorted importance. The mother doesn't know her baby will settle down after being burped on the way back to the nursery, or that her milk supply will automatically adjust to his needs.

As for the use of clinical terms: *You* understand that colostrum is a fluid preceding the flow of milk, that it is a food with a beneficial laxative effect. But does the new mother? A



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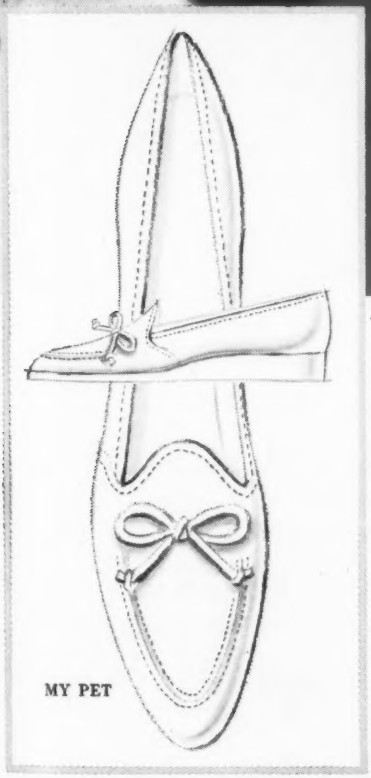

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simple explanation will increase her understanding of the wonderfully inclusive advantages of breast feeding.

Frequently the nursing mother complains of a "drawing" sensation in the lower abdomen. Once she knows this occurs because the baby's sucking action stimulates contraction of uterine muscles, she will accept the discomfort with aplomb. Even the least vain of us is interested in resuming the pre-pregnancy silhouette as soon as possible.

The mother may also become concerned about whether or not the baby is getting enough milk. Pooh-poohing such fear is seldom effective. But I've seen a waning confidence soar when the patient was provided with extra fluids and encouraged to offer both breasts at a feeding. (She was told, of course, to make sure the baby always emptied the due side before he nursed at the other.)

* * *

Those are some of the ways a nurse can help. You can think of many others. The important point is this:

In maternity nursing we can render service with far-reaching benefits for baby and mother. Many unaggressive, inarticulate mothers need our help. It's the quality of perceptiveness, the quiet awareness of such need, that distinguishes the superior from the ordinary R.N. END

Heart stopper

The wife of my heart-arrest patient in oxygen questioned anxiously: "What's the tent for? How is he now?"

The tent seemed too hot so I asked Susie, a young nurse, to check it with me. As she unzipped it, the wife said: "What are you doing?" Without answering, Susie stuck her blonde head into the opening.

"Nurse," the wife wailed. "Don't do *that!* If Bill opens his eyes, he'll think you're an angel. The shock will kill him!"

Sequel: He did. It didn't. He recovered.

—EVELYN BUENGER, R.N.

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ANESTHESIA COURSE: The Cincinnati General Hospital School of Anesthesia offers an 18 month course of training in anesthesia for registered nurses. Instruction in all type of anesthetic techniques, including endotracheal intubation, spinal block, etc. Accredited by the American Association of Nurse Anesthetists. For information write Director School of Anesthesia, Cincinnati General Hospital, Cincinnati 29, Ohio. No tuition, complete maintenance, monthly stipend during last 6 mos.

ANESTHETIST NURSES: The Albany Medical Center School for Nurse Anesthetists, associated with Albany Medical Center Dept. of Anesthesiology, offers an 18 month course of training for registered nurses. Course begins each Sept. 1. Accredited by the AANA G.I. approval full maintenance throughout plus progressive stipend after 3 mos. For information write Miss Florence M. Maleck C.R.N.A. Albany, N. Y.

ASSISTANT DIRECTOR IN CHARGE OF NURSING EDUCATION: 500 bed voluntary hospital. Master's degree preferred but will consider B.S. with satisfactory experience Salary dependent on education & experience. Nationally accredited school of approximately 100 students, liberal personnel policies. Universities & colleges available both in New York & New Jersey for further education, 10 miles from New York City, with direct transportation to Times Square in 35 minutes. Write to Director of Nursing, Newark Beth Israel Hospital, 201 Lyons Ave., Newark 12, N. J.

ASSISTANT NURSING DIRECTOR: Starting salary $6807 per yr., 40 hr. wk. Primary function of in-service education in 500 bed suburban Detroit general hospital, moving into beautiful new facilities this yr. Also shares administrative responsibility for nursing service with Nursing Director, Master's degree desired, will consider B.S. degree applicants with education experience. Liberal fringe benefits including 11 pd. holidays, up to 3 wks. vacation, retirement plus social security plan. Contact Nursing Director, General Hospital, Wayne County General Hospital, Eloise, Mich.

CALIF. REGISTERED NURSES: Needed for staff duty in JCAH, 428-bed hospital. Good benefits & salary. Personnel Director, Hospital Good Samaritan, 1212 Shatto St., Los Angeles 17, Calif.

CLINICAL CO-ORDINATOR: Maternal, Infant Care & Pediatric nursing, available June, 1961, in a small diploma school (30 students admitted yearly) in the largest hospital (240 beds) in the Berkshires (Western Mass.). Moving to new facilities Fall, 1961. A challenging opportunity for a qualified nurse with initiative, co-ordination of instruction in pediatric & obstetrical nursing is planned. Personnel policies include salary commensurate with experience, pd. vacation, sk. lv., 7 pd. holidays, hospitalization insurance, rooms available in area. Community is noted for year-round recreational & cultural activities and is equal distance from New York City & Boston by rail or throughways. Apply Director of Nurses, Pittsfield General Hospital, 741 North St., Pittsfield, Mass.

CLINICAL INSTRUCTOR: Maternal & Child care, available June, 1961, in a small diploma school (30 students admitted yearly) in the largest hospital (240 beds) in the Berkshires (Western Mass.). Moving to new facilities Fall, 1961. A challenging opportunity for a qualified nurse with initiative. Position includes planning educational experience in obstetrical unit for professional & vocational practical nurse students. Personnel policies include salary commensurate with experience, pd. vacation, sk. lv., 7 pd. holidays, hospitalization, insurance, rooms available in the area. Community is noted for year-round recreational & cultural activities and is equal distance from New York City & Boston by rail or throughways. Apply Director of Nurses, Pittsfield General Hospital, 741 North St., Pittsfield, Mass.

CLINICAL INSTRUCTORS: Medical Surgical nursing, Obstetrics & Psychiatry. 525 bed hospital, 170 students, degree & experience required, salary commensurate with qualifications. Apply Director of Nursing, Missouri Baptist Hospital, 919 North Taylor Ave., St. Louis 8, Mo.

CLINICAL INSTRUCTORS: Obstetrics, Pediatrics & Medical nursing. 450-bed modern general hospital with separate building for obstetrics. Diploma program with 200 students in NLN fully accredited school. B.S. degree required & experience desired. Liberal personnel policies, located in Northwest, near skiing & ocean. Apply Director, School of Nursing, Good Samaritan Hospital, Portland 10, Ore.

COMMUNITY HOSPITAL: The most progressive modern hospital in the mid-west needs nurses. Salaries $306 per mo. for days, $349 for evenings, $339 for nites. Above salaries based on the first years' average salary. Apply to Miss Alys Kline, Director of Nursing Division, 1500 N. Ritter Ave., Indianapolis, 19, Ind.

DELIVERY ROOM NURSES: For modern 189 bed J.C.A.H. accredited hospital approximately 100 miles from New York City &

Boston, Mass. Unit air-conditioned throughout, good personnel policies, 40 hr. wk. Please write Director od Nursing, Mount Sinai Hospital, Hartford, Conn.

DIRECTOR OF NURSING SERVICE: For a 152 bed Methodist affiliated hospital with a small but expanding student nurse diploma school. There will be no responsibility in nursing education other than coordination with tne director of the school of nursing. Hospital has recently built a new addition and the rest of the hospital almost completely remodeled. Good salary, usual personnel policies, prosperous & growing community. Apply Administrator, Grace Hospital, Hutchinson, Kans.

DIRECTOR OF NURSING SERVICE: Excellent opportunity for qualified person. General hospital, fully accredited, 500 beds, large southern city, salary open, excellent management policies & the best fringe benefits including group life & pension plan. Write Box SBH, c/o RN Magazine, Oradell, N. J.

FACULTY POSITIONS: Available in school of Practical Nursing for September or earlier. Excellent salary. Apply to Director of Nursing, Wyckoff Heights Hospital, 374 Stockholm St., Brooklyn, N. Y.

FORT MYERS, FLA: "The City of Palms", Nation's fastest growing area. Yearly average temperature 72°. R.N.'s & L.P.N.'s, 40-hr. wk., good pay & extra benefits. Write Director of Nursing, Lee Memorial Hospital.

FORT MYERS, FLA.: "The City of Palms." R.N's general duty in hospital serving Negro patients. Minimum salary $300 per mo., shift bonus, 40-hr. wk., 8-hr. day, 6 holidays a yr., Blue Cross Hospitalization, & other fringe benefits. Director of Nursing, Jones-Walker Hospital, Fort Myers, Fla.

GENERAL DUTY NURSES: Resort area in High Sierras, J.C.H.A. accredited, 31 bed hospital. Wirte or call Administrator, Northern Inyo Hospital, Bishop, California—UPton 3-3594.

GENERAL DUTY NURSES: For 72 bed hospital located in college town in mountainous portion of Colo. Salary $350 per mo. with periodic increases, fringe benefits including meals, sk. lv., vacation, etc. Contact Superintendent, Alamosa Community Hospital, Alamosa, Colo.

GENERAL DUTY NURSES: 84 bed hospital, finest equipment, 40 hr. wk., very liberal personnel policies, pleasant working environment, rotating shifts, salary range $337.99 to $457.59 mo., $20 evening and night differential. Atomic Energy Project, not civil service. Write Director of Nurses, Los Alamos Medical Center, Los Alamos, N. M.

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GENERAL STAFF NURSES: Positions available in all services & on all shifts in 320 bed general hospital. Starting salary $280 mo. with differential for evenings & nights. Rooms available in the nurses' residence. The University of Arizona School of Nursing offers additional educational opportunities. Contact Ass't. Director of Nursing Service, Tucson Medical Center, Tucson, Ariz.

GRADUATE NURSE: Well qualified to direct a brand new modern pediatric unit of 36 patients. Will also teach pediatric nursing to small good student body, pleasant cooperative staff. Master's degree preferred, baccalaureate degree acceptable. Apply Personnel Office, New Rochelle Hospital, New Rochelle, New York.

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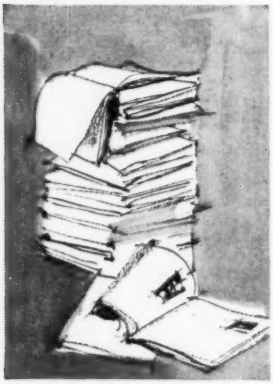

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Cronk, G. A. Laboratory and clinical studies with buffered and nonbuffered acetylsalicylic acid. **New Eng. J. Med.**, vol. 258, p. 219-221, 1958.

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Rubin, R., Pelikan, E. W., and Kensler, C. J. Effects of unbuffered and buffered acetylsalicylic acid on intragastric pH. **New Eng. J. Med.**, vol. 261, p. 1208-1212, 1959.

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HIGH CALIBER REGISTERED NURSES: We need good nurses interested both in latest scientific therapy & old-fashioned warm care of patients with cancer & allied diseases. Teaching & research center offers valuable experience. Adequate staff of top nurses maintained. University-affiliated in-service education; access all NYC educational programs. Good basic preparation required; learn specialty here where patients receive active surgical-medical-radiation therapy. Not a chronic disease hospital. Staff Nurses, day $366-$409 mo., evening $421-$464, night $410-$453, 4 wk. vacation, 1½ pay for overtime, Blue Cross pd., uniforms laundered, minimum rotation, furnished apartments available through Housing Agent. New 20 story apartment house overlooking East River opens April 1962. Suture Nurses: base salary plus ½ pay for on-call. Mary Connolly, R.N., Director of Nursing, Memorial Hospital, Memorial-Sloan-Kettering Cancer Center, 444 E. 68th St., New York 21, N. Y.

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NURSES: Two registered general duty nurses for small general hospital, days $400, P.M. $435. Apply by writing Box 336, Dos Palos, Calif. or phone EX 2-3450 after 6 p.m. (collect).

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NURSES: For new 75 bed general non-profit hospital. Resort area. Contact Administrator, South Coast Community Hospital, South Laguna, Calif. HYatt 4-8501.

NURSES: Live in the Land of Enchantment where opportunities are awaiting you. Have opening for obstetrical and general duty RNs in accredited hosp. which is situated in a growing and thriving community with ideal climate. Salary range $300-400 mo. for 44 hr duty. Liberal personnel policies. Sick lv plan with 6 holidays per yr. Also we pay differential of $10 extra PMs. If interested please contact Administrator, Clovis Memorial Hospital, Clovis, N. Mex.

NURSES: General duty, 236 bed hospital, 30 mi from NYC. Apartment-style residence. Good salaries, free benefits and pension plan. Modern hospital. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N. J.

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1. Kane, S.: Am. Pract. & Digest Treat. *8*:65 (Jan.) 1957.

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OPERATING ROOM & GENERAL DUTY NURSES: New, modern, well-equipped 63-bed hospital located in scenic horse country of Virginia. All advantages of country living, yet only 45 minutes out of Washington. Liberal salary, good personnel policies. Apply Administrator, The Fauquier Hospital, Warrenton, Va.

OPERATING ROOM NURSES: New air-conditioned suite, 50 bed accredited hospital. Opportunity to advance, salary $350 to $400 per mo., 40 hr. wk. Apply Administrator, Crawford County Memorial Hospital, Denison, Iowa.

OPERATING ROOM NURSES: All shifts, rotating or permanent evening & night assignment, 400 bed hospital, 40 hr. wk., planned merit increases, substantial evening & night differential, retirement pension plan, Blue Cross, Social Security, liberal vacation & sk. lv. policy. Convenient transportation to education & cultural facilities accessible, good residential area. Apply to Director of Nursing, West Suburban Hospital, Oak Park, Ill.

OPERATING ROOM NURSES: 160 bed general hospital located in a beautiful residential section along the North Shore of Chicago. Starting salary $390 for days, $420 for evenings, 40 hr. wk. Modern ranch style nurses' homes with attractively furnished private bedrooms. Contact Personnel Director, Highland Park Hospital Foundation, Highland Park, Ill.

OR AND GENERAL DUTY NURSES: New 65 bed hospital, College town, to be opened early 1961. Contact Director of Nurses, Hillcrest General Hospital, Silver City, N. M.

OR & STAFF NURSING: Active 100 bed children's medical center. University affiliation. Good personnel policies. Apply Director of Nursing, St. Christopher's Hospital for Children, 2600 N. Lawrence St., Philadelphia 33, Pa. Telephone GA 6-5600.

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PROFESSIONAL NURSES: To staff 2,000 bed teaching hospital affiliated with Stanford Univ., in beautiful Santa Clara Valley, 30 miles south of San Francisco, near beach & mountain resorts. Head, staff nurse & supervisory positions available. Opportunities for advancement in administration & education due to activation of new 1000 bed division. Current license from any state acceptable, annual salaries $4760-$7560 depending on education & experience, uniform allowance & laundry, normally 40 hr. wk., 8 holidays, 30 days vacation, 15 days sk. lv. (cumulative), retirement & health plans, continuous in-service education. Clinical area: Psychiatry, Neurology, Medicine, Surgery, Geriatrics, Operating Room. Write Chief, Nursing Service, Veterans Administration Hospital, Palo Alto, Calif.

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REGISTERED NURSES: For general duty in modern 89 bed general hospital, located in famous Mother Lode area of Central Calif. General duty salary $340 to $360, $15 differential, 40 hr. wk., excellent fringe benefits. Write Administrator, Mark Twain Hospital, San Andreas, Calif.

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STAFF & SURGERY NURSES: Challenging opportunity to broaden your nursing experience, in this unique 104 bed, State owned cancer hospital. Local colleges & university for advanced study. Excellent personnel policies. Write to Director of Nurses, Ellis Fischel Cancer Hospital, Columbia, Mo.

STAFF NURSES: 600 bed JCAH accrredited hospital located on Florida's Gulf coast. Affiliating agency for professional & practical students. Starting salary $290 days, $307 evenings & nights. Positions also available for licensed Practical Nurses, starting salary $216 days, $229 evenings & nights. In-service program, annual merit increases, 8 holidays, sk. lv., & vacation benefits. Apply Director of Nursing, Mound Park Hospital, St. Petersburg 1, Fla.

STAFF NURSES: A large community hospital has attractive positions in all areas of nursing. Excellent promotional opportunities, starting salary range is $4200-$4950 per annum. Apply Personnel Department, Hartford Hospital, Hartford, Conn.

STAFF NURSES: For modern, large tuberculosis hospital in suburban Cleveland. Starting salary $370 with semi-annual increments. Extra for night and relief duty, non-rotating shifts, opportunities for advancement, pd. vacation and holidays, liberal sk. lv. cumulative to 90 days. Progressive retirement plan with employer matching contributions includes disability and survivor benefits. Attractive, completely furnished 2-bedroom homes available at very low rent including utilities for two single nurses or married nurses. Write Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

STAFF NURSES: 245 bed general hospital fully accredited, 40 hr. wk., 2 wks. vacation, 6 pd. holidays, 12 days sk. lv. annually, good recreational area. Starting rate $330. Apply Director of Nursing Service, Memorial Hospital, Casper, Wyo.

STAFF NURSES: For JCAH accredited 210 general hospital with diploma school of nursing, 35 miles from New York City. Rotating staff, salary range $335 to $375 per mo; $50 differential for 3-11 duty, $40 differential for 11-7. Liberal personnel policies including generous sk time and vacation allowance. Pleasant living facilities provided at $30 per mo. Call or write Director of Nursing, White Plains Hospital, White Plains, N. Y. Telephone WHite Plains 9-4500.

STAFF NURSES: 238 bed So. Calif. hospital. Salary Calif. registered nurses starts at $330. Merit increases. Apply Director of Nursing, Cottage Hosp., Santa Barbara, Calif.

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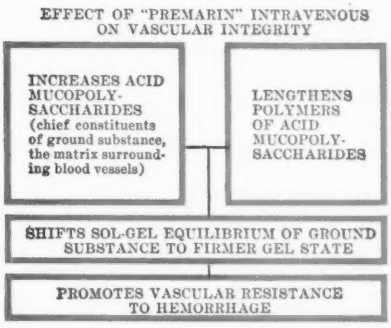

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*Schiff, M., and Burn, H. F.: A.M.A. Arch. Otolaryng. 73:43 (Jan.) 1961.

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